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ABSTRACT

The Asian Women's Health Project undertook four activities to develop a model for delivery of family planning services to Asian and Pacific women: (1) a key informant survey was used to collect data from Asian and Pacific community, social, and health workers currently serving Asian and Pacific men and women; (2) an information and referral review surveyed administrators and practitioners who provided family planning services within or near a Californian Asian and Pacific community, in order to identify problems in family planning service delivery; (3) a consumer survey was administered to 200 Asian and Pacific women to identify their needs and preferences; and (4) a statistical search and literature review were undertaken to identify, review, and analyze recent demographic data and health statistics on Asian and Pacific women in the Los Angeles area. Recommendations were made to Federal and California State and local agencies in order to resolve difficulties resulting from underutilized services and the lack of bilingual/bicultural health personnel and health education information. Data collection tools and statistical information are appended. (Author/MK)

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ASIAN PACIFIC WOMEN: Cultural Aspects of Family Planning

A Study by the Asian Women's Health Project

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ASIAN PACIFIC WOMEN: Cultural Aspects of Family Planning

A Study by the Asian Women's Health Project

Research and Analysis by:
Teresa Takaki Matsushima
Linda Miya Iwataki

Final Writing and Editing by:
Linda Miya Iwataki
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I. INTRODUCTION

The Asian Women's Health Project (AWHP) was developed to begin work that would address family planning and related health needs of the Asian/Pacific community in Los Angeles County.

Specifically, the project investigated family planning and related health needs by conducting a close inquiry into both written and oral primary sources, and by developing a family planning service delivery model that would meet the needs of the Asian/Pacific community. The objective was to design a model that could be applicable at a national level and that also could be used by other ethnic minority communities with similar cultural characteristics.

Funding for the project was provided by the Asian/Pacific Study Grant, under the joint sponsorship of three organizations: T.H.E Clinic-For Women, Inc., the Los Angeles Regional Family Planning Council, Inc., and the Asian American Studies Center, University of California, Los Angeles. Appendix A to this report contains background information on each one of the sponsoring organizations.

Recent statistics have shown that the Asian/Pacific population in L.A. County has doubled since the 1970 census, to reach a total of more than 534,000 persons. Much of this growth is due to high immigration rates, especially during the past 5 to 8 years. Many factors have contributed to this situation: the war in Indochina, the economic crisis in many Asian countries, and expansion of business (e.g., from Japan into the United States). The 1965 repeal of national quotas on immigration also has been an element of influence. These factors, coupled with the unique cultural and geographic particularities of the different Asian and Pacific Island countries, have created a complex and intricate Asian/Pacific community in Los Angeles County.

The situation has not been fully appreciated or dealt with. Bilingual and bicultural services to Asian/Pacifics have not increased at the same rate as that of the growth of the community. In fact, there are still significant gaps in the provision of good health care services for Asians in general. For Asian women, in particular, there are gaps in the area of family planning services. This lack has become an important concern because the number of Asian/Pacific women within the childbearing years of 15 to 44 has increased significantly. Data from the 1970 census of the City of Los Angeles (Standard Metropolitan Statistical Areas) indicate that Japanese and Chinese women in the range of 15 to 44 years compose 25 percent of their respective populations, and Pilipina[1] women in that age range account for 28.5 percent of their ethnic group.

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[1] "The term 'Pilipino' is used...in reference to persons whose place of origin is the Pilipine Islands. There is no 'f' sound in the Pilipino language and the Pilipino community prefers this spelling and pronunciation." Quotation from "A Study of Selected Socio-Economic Characterics of Ethnic Minorities. Based on the 1970 Census," Vol.2: Asian Americans. Arlington, Virginia: Urban Associates, Inc., 1974, page XII.

With the increase in immigrant families in the population, the numbers of families and individuals in poverty have also proportionately increased. The situation is due to high rates of unemployment, an increase in the number of households headed by women, and financial responsibilities of immigrants to extended families in the United States and in their native countries. Many immigrants continue to support families that remained behind because of immigration restrictions.

Given this expressed need, the Asian Pacific Study Grant was initiated to develop a model for delivery of family planning services that would address the specific needs of Asian/Pacific women.

Several other considerations needed to be taken into account. In addition to the above needs, the Asian/Pacific community in Los Angeles has a unique character in that it encompasses various ethnic groupings including Japanese, Chinese, Korean, Pilipino, Samoan, Vietnamese, Cambodian, Lao, Thai, and Guamanian peoples. Each group possesses very diverse characteristics that give rise to specific needs. Of particular concern is the need for further investigation and insight into the special problems of the recent Asian/Pacific immigrant women.

Culture and language are vital considerations in the formulation of any human service, but they are particularly important in the development of models that incorporate these considerations into their design for delivery of family planning services to the Asian/Pacific populations.

This report consists of a description of four major activities and the recommendations they produced:

Key Informant Survey - To identify data not available through standard statistical sources, the survey focused on key Asian/Pacific community, social and health workers currently serving Asian/Pacific women and men. Ten Asian ethnic communities were targeted: Japanese, Chinese, Korean, Pilipino, Samoan, Vietnamese, Cambodian, Thai, Lao, and Guamanian. An initial investigation also was made of family planning needs among the Asian handicapped.

Information and Referral Review - The review surveyed administrators and practitions from a sampling of LARFPC family planning providers (hospitals, free and community clinics, County clincs) located within or near an Asian/Pacific community. The purpose was to identify problems in the delivery of family planning service to Asian/Pacific women and men, and to increase administrators' and practitioners' awareness of the Asian/Pacific community and its need for family planning services.

Consumer Survey - The survey was administered to about 200 Asian/Pacific women to identify consumer preference and need. The surveys were translated into six languages: Japanese, Chinese, Korean, Vietnamese, Lao, and Thai. The majority of the English-speaking and non-English-speaking women expressed a desire for bilingual/bicultural health personnel, with a preference for women health workers.

Statistical Search and Literature Review - The combined effort was undertaken to identify, review, and analyze recent demographic data and health statistics on Asian/Pacific people in Los Angeles County. Data were collected from numerous sources representing the County, the City the local community groups and agencies, and the LARFPC structures.

Recommendations - The severe under-utilization of family planning services by Asian/Pacific women and men, and the critical need for bilingual/bicultural health personnel and health education information were upheld and supported by the information from all components of the Asian Pacific Research project. Specific recommendations resulting from the study are presented in Section II, immediately following.

II. CONCLUSIONS AND RECOMMENDATIONS

A. Major Conclusions

The findings of the Key Informant Survey revealed the under-utilization of services by the Asian/Pacific community, the need for subsidized family planning and health services for low-income Asian/Pacifics, the need for bilingual/bicultural health personnel, and the need for translated materials on health education. The in-depth interviews also underscored the integral way in which family planning practices were intertwined with attitudes toward health, financial situation, living situation, years of residence in the United States, relationships within the family and between partners, attitudes toward the role of women, and so on. It became apparent that family planning could not be approached as a phenomenon isolated from the overall quality of life.

The results of the Information and Referral Review substantiated findings regarding the under-utilization of family planning services by the Asian/Pacific community, given even a good location with easy accessibility. It also highlighted the need for Asian/Pacific bilingual/bicultural workers, educational materials, and outreach into the Asian/Pacific communities surrounding or close to family planning clinics. Most of the providers interviewed were not aware of the fact that Asian/Pacific residents composed a significant segment of the population in the catchment areas. They did not have information about which Asian ethnic group was residing in the area or what characteristics of the Asian/Pacific population.

The Consumer Survey was conducted among Asian/Pacific women of varied backgrounds, incomes, and ages. The majority of both English speaking and non-English-speaking women expressed a desire for bilingual/bicultural health personnel, with a preference for women health workers. Understandably, the non-English-speaking women showed a much higher need in this regard and indicated the greatest degree of under-utilization of basic health services as well as family planning services. Both English-speaking and non-English-speaking women put forward a long list of health education areas including preventive health care (high on the list), family planning, menopause, prenatal care, vaginal infections, health consumer issues, diet-exercise-nutrition, and basic health education.

The findings of the Statistical Search showed conclusive evidence of the rapid growth of the Asian/Pacific community in Los Angeles County, the large percentage of Asian/Pacific women of childbearing age, and the significant number of low-income Asian/Pacific women of childbearing age. It also brought out clearly the institutional barriers manifested by the severe under-utilization of family planning services by Asian/Pacific women, and revealed the continued critical lack of primary resources of information on the Asian/Pacific community.

One major limitation in extensive statistical analysis was the lack of available data on Asian/Pacific women and their use of health care services. The standard application of the Dryfoos formula developed by the Guttmacher Institute could not be adapted to determine family planning needs of Asian/Pacific women. Data on several factors used in the formula (e.g.,) percentage of sexual activity, percentage of women sterilized, percentage of women sexually inactive due to pregnancy, age, etc.) are not available for Asian/Pacific women. The standard percentages available on black and white women could not be applied to Asian women because of cultural and population differences.

The analysis also pointed up a need to conduct further research on Asian/Pacific women and health, to determine more complete figures regarding need and utilization on a national basis.

The Literature Review of family planning models and attitudes helped to trace the roots of those attitudes and/or the carry-overs building cultural barriers for Asian/Pacific women in regard to family planning. This knowledge increased clarity and sensitivity in understanding and approaching the problem. Major factors impacting on the family planning attitudes and practices of Asian/Pacific women and men were identified in the areas of religion (teachings of missionaries), the Confucian philosophy, the importance of children in an agricultural society, and the economy and politics of the various Asian and Pacific Island countries.

It is important to integrate an understanding of these factors into training programs for staff members attempting to provide effective services to Asian/Pacific women. The same understanding to persons formulating policy on health care issues, and developing models for delivery of family planning services to Asian/Pacific communities.

One overall conclusion of the study was recognition of the need to begin developing models specific to different Asian/Pacific communities. The models would include such factors as geographic location, percentage of recent immigrants, language needs, availability of family planning services, availability of community resources, and so on. A specific model to be tested in Los Angeles County has been developed as a result of the study, but other models for specific geographic locations should be instituted on the basis of appropriate research.

The study also substantiated the fact that for Asian/Pacific women family planning is an essential part of general health and reproductive health concerns. It is an important factor in developing the overall quality of human life. The recent trend by

DHEW and other governmental agencies to consider family planning as a part of overall reproductive health needs is supported by the findings of this study.

B. Recommendations

The following recommendations are made to Federal, State, and local governmental agencies mandated to fund or develop health care programs. The recommendations are based on the findings and conclusions of this report.

1. Recommendations to Agencies of the Federal Government

a. Family planning materials developed by the Department of Health, Education, and Welfare (DHEW) and other Federal agencies be translated into major Asian languages.

b. Allocate special funds to assist clinics in areas with a high concentration of Asian/Pacific peoples, so that the agencies may develop outreach, education, and interpretation services for Asian/Pacific communities.

c. Require, as a mandated function, that an agency receiving Title X funds or other Federal health dollars provide services to Asian/Pacific communities if one Asian ethnic group accounts for more than 5 percent of the population in the agency's catchment area.

d. Require, as a mandated function, that agencies receiving Title X funds or other Federal dollars report statistics on use of services by Asian/Pacific ethnic groups.

e. Develop national training institute to support research on family planning needs of Asian/Pacific women; provide traning to staff and policy-makers; and translate developed materials into different Asian/Pacific languages.

f. Make Asian/Pacific persons available to assist agencies interested in improving services to the Asian/Pacific community. It is recommended that DHEW provide consultation services and ensure that persons with expertise regarding women's health care issues of the Asian/Pacific community assist in evaluating clinic sites located near high concentrations of Asian/Pacific residents. Recommendations of consultants should be sought, and technical assistance should be solictied from local community agencies whose staff members have family planning and community needs.

g. Develop special programs to provide women's health care services for specific Asian groups: handicapped, drug abusers, and alcohol abusers. Conduct additional investigation in these areas.

h. Continue other research and program development efforts in areas related to women's health care,(e.g., teen pregnancy, sexuality, utilization), within the Asian/Pacific communities.

Similar recommendations would be made to State agencies especially with respect to recommendations c. and d; but in terms applicable to clinics or agencies receiving State dollars.

2. Recommendation to Agencies of the State of California

a. Develop and conduct 80 hours of training (20 hours per week for 4 weeks) for four bilingual/bicultural community health workers from the Asian/Pacific community. The tranining would cover family planning philosophy and terminology, basic anatomy and physiology of reproduction, methods of contraception including natural family planning methods, communication skills, outreach techniques, and community assessment.

b. Develop and implement a public relations package for presentation by Asian/Pacific radio, television, vernacular press, organizational communication organs, and other established media. The package would include 12 newspaper articles, 12 radio spots, and 6 television spots.

Goals and Objectives

c. Conduct weekly education/outreach sessions for men and women within the Asian/Pacific communities. Subjects would include sex education, family planning, women's basic health care, consumer rights, etc. Assuming an average group of 30 persons at each one of two 1-hour sessions per week, a 40-week series of presentations would reach 2,400 persons.

d. Develop and conduct 32 hours of in-service staff training for non-Asian staff members at four clinics (8 hours at each one of four clinics). Participating staff members would receive background information on the Chinese, Japanese, Korean, Pilipino, Samoan, and Indochinese cultures.

e. To provide one interpreter for 14 hours per week for 40 weeks, at each one of four locations: John Wesley Hospital, T.H.E. Clinic for Women, Inc., Los Angeles County Harbor/UCLA Medical Center, and Planned Parenthood World Population, Inc. The interpreters would be present for intake appointments, education sessions, examinations, followup interviews, etc.

f. To provide 300 hours of assistance to LARFPC-funded clinics and Asian community agencies in consultation, interpretation, and referral. The assistance, to be provided on an as-needed basis, would deal with family planning and women's general health care.

g. Publish and distribute 500 copies of a multi-lingual handbook on women's health care and family planning. The handbook would be published in the Japanese, Chinese, Korean, Samoan, Vietnamese, and English languages for distribution to clinics and Asian/Pacific community agencies in California.

h. Publish and distribute 5,000 copies of three educational pamphlets covering the areas of male/female anatomy, birth control methods, preventive health measures, and sexually transmitted diseases. The pamphlets would be published in the Chinese, Japanese, Korean, Samoan, Vietnamese, and English languages for distribution among consumers (especially teenagers), community agencies, and family planning clinics.

i. Develop translation network to provide services in additional Asian/Pacific languages.

j. Fund telephone information line with the capability of providing services to different Asian/Pacific non-English-speaking persons. The line would provide information regarding basic family planning and referrals.

k. Encourage hiring of additional Asian/Pacific bilingual staff by agencies with clinics located in high concentrations of Asian/Pacific residents.

Recommendations a. through k., above, were submitted as a Statement of Work in a proposal which was accepted by the State of California, Department of Information and Education. The proposal has been funded by a grant running from July 1979 through June 1980.

III. OBJECTIVES

Prior to initiation of the Asian Women's Health Project, very little research had been done regarding Asian/Pacific women and health, and no formal research and investigative study had been conducted in the area of family planning. The rapidly growing Asian/Pacific population in Los Angeles County, and the existing lack of information regarding family planning and its practice within many Asian/ Pacific countries warranted attention to the subject.

In light of the critical and long-ignored need, three basic objectives for the Asian Women's Health Project were identified:

- To analyze existing data regarding Asian/Pacific community throughout Los Angeles County
- To evaluate models of family planning and service delivery to identify those applicable to Asian/Pacific communities
- To develop an overall plan for the delivery of family planning services to Asian/Pacific communities throughout Los Angeles County

Several perspectives maintained by the Asian Women's Health Project throughout its work included sensitivity to the diverse nature and character of the many Asian ethnic groups; emphasis on devoting special attention to the problems of recent immigrants; recognition of the need to check back all information, findings and tentative conclusions with the community to be served; and openness to identifying and noting for future work any other areas of need uncovered through the work of the project (e.g., lack of translated educational materials on family planning).

In the first month of the project, an assessment was made of the tasks ahead, and five additional sub-objectives were identified:

- Review of the current family planning literature available to the Asian/Pacific community
- Identification of needed educational and informational materials on family planning for Asian/Pacific women
- Investigation and definition of cultural and institutional barriers to Asian/Pacific women's use of family planning services
- Conduct of a key informant survey to determine the areas of need in the Asian/Pacific community by obtaining data not available through standard statistical sources
- Investigation of unique groupings within the Asian/Pacific community that need special attention in regard to family planning (e.g., drug abusers, alcoholics, mentally and physically handicapped persons, Asian women prisoners)

IV METHODOLOGY

A. Areas of Effort

The Asian Women's Health Project concentrated on four tasks, with specific objectives for each task.

1. Statistical Search and Literature Review

- To identify and extract pertinent information from available demographic data on Asian/Pacific people in Los Angeles County.
- To analyze existing available health data on the Asian/Pacific community in Los Angeles County, with a specific focus on family planning and related areas of concern.
- To research and review family planning practices and birth control usage and attitudes in other Asian/Pacific countries in order to make a comparative analysis of effects and impacts on the Asian/Pacific community in Los Angeles County.
- To present the research results in chart and written form in order to provide the first resource for concentrated information on Asian/Pacific women and family planning in Los Angeles County.

2. Information and Referral Review

Objectives:

- To contact at least 10 LARFPC agencies geographically located within or near heavily populated Asian/Pacific areas in Los Angeles County, to determine the extent to which agency services are being used by Asian/Pacifics.
- To contact at least 10 LARFPC agencies geographically located within or near heavily populated Asian/Pacific areas in Los Angeles County, to determine the availability of the agencies to the Asian/Pacific community.
- To interview the administrators and/or practitioners at each of these facilities, to determine the level of knowledge about the Asian/Pacific community and therefore the extent of outreach to it; and to learn the number of workers in health and human service available to the Asian/Pacific community at each facility.

3. Key Informant Survey

Ojectives:

- To identify and contact community service personnel and health providers with current practice among members of 10 Asian ethnic communities.

- To conduct person-to-person interviews with these key informants in order to achieve the following:

  - Ascertain additional health-related and family planning data not available through standard statistical sources.

  - Obtain an initial assessment of how each one of the 10 specific Asian/Pacific communities perceive family planning; (determine various Asian/Pacific community attitudes toward family planning.

  - Identify reasons to for use or non-use of existing family planning service delivery models; define institutional and cultural barriers preventing fuller use of existing family planning services.

- To identify primary recommendations for implementation of direct services and education in family planning for the Asian/Pacific community.

4. Consumer Survey

Objectives:

- To collect data from a sample of 10 different Asian/Pacific communities.

- To test conclusions reached from the Literature Review and Statistical Search, Information and Referral Review, and Key Informant Survey; to compare these conclusions regarding health and family planning needs of Asian/Pacific women with opinions of the population to be served.

- To gather personal health data from a small, in-depth sample of women from 10 Asian/Pacific communities.

- To gather further information from these women regarding type of health services being sought, facilities currently being used, and problems faced in seeking health care.

- To determine the health education needs of the community.

Limitations

The Asian Women's Health Project study was limited by the lack of information available on actual family planning services being provided to the Asian/Pacific community. In addition, there was a virtual void of information on Asian/Pacific women and family planning, as well as an almost complete lack of concrete data on Asian/Pacific women and health. This situation resulted in a stronger emphasis on the personal interviews and surveys conducted with staff members of existing hospitals and clinics, health care providers and community workers, and the Asian/ Pacific consumers themselves. These tasks contributed to the need for an extension of time.

Another primary constraint was the limitation of funds. The proposed life of the project was 6 months. Within the first month, the immensity of the work, with the glaring lack of primary resources and research in the field, indicated the need for a longer work period. The funding, therefore, had to suffice through the time extension.

This factor contributed to a number of limitations. Staffing was limited to two persons for the first 9 months, after which there was barely enough funding for one staff member. Because of limited staffing, the project could concentrate on only 10 Asian/Pacific communities in Los Angeles County. This in itself was an enormous task, in view of the many different languages, dialects, and cultural characteristics involved. Also, the population being dealt with encompassed third and fourth-generation Asian Americans as well as newly arrived immigrants, with all of their accompanying different attitudes toward health and family planning.

Given these serious limitations and the extremely broad scope of the project's intentions, the quality and quantity of work performed, the information gathered, the contacts made, and the presentation and consulting services given by the staff exceeded the amounts called for in the project's Statement of Work.

V. PRESENTATION OF FINDINGS

A. Key Informant Survey

The Key Informant Survey is one of the most frequently used approaches in needs assessments. Needs assessments have a threefold purpose. "They are intended to provide data on the basis of which agencies will be able to: (1) identify the extent and kinds of needs there are in a community, (2) evaluate systematically their existing programs, and (3) plan new ones in the light of community needs and health service patterns."[1]

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[1] Warheit, George J.; Bell, Roger A.; and Schwab, John J.: Needs Assessment Approaches: Concepts and Methods. U.S. Department of Health, Education, and Welfare, 1977, p.4.

[2] Ibid., p.11.

[3] Ibid., p.20.

The cited DHEW report goes on to say: "The initiation of a needs assessment survey without prior commitment to use the data for planning purposes is often a waste of resources and, equally important, is likely to produce or intensify conflicts within the agency. It may also increase expectations in the community. If service programs are not forthcoming to meet identified needs, alienation, frustration, and hostility toward the agency may develop. Hence, needs assessment programs ought to be conducted only by those who are committed to planning for change through serious research.

The report also describes criteria for the selection of key informants:

> The key informant approach is a research activity based on information secured from those in the area who are in a position to know the community's needs and utilization patterns. Therefore, the selection of a key informant is based on the individual's knowledge of the community, its people and their needs, and the patterns of services.

Several objectives were identified for the Key Informant Survey:

- To identify and contact community service personnel and health provides with current practice among 10 ethnic communities of Asian nationality.
- To conduct personal interviews with those key informants for the following purposes:
  - To secure certain health-related and family planning data not available through standard statistical sources.
  - To obtain an initial assessment of how each of the specific 10 Asian/Pacific communities perceives family planning; and to determine various Asian/Pacific community attitudes toward family planning.
  - To identify reasons for the use or non-use of existing family planning service delivery models; and to define institutional and cultural barriers preventing fuller use of existing family planning services.
  - To obtain an assessment from health care providers and community workers on how each ethnic community perceives an effective service delivery system.
- To identify primary recommendations for implemention of direct services and education in family planning and health for the Asian/Pacific community.

Twenty-six in-depth interviews were conducted with key persons from the Japanese, Chinese, Korean, Pilipino, Samoan, Vietnamese, Lao, Cambodian, Thai, and Guamanian communities.

(see Exhibit 1)

KEY INFORMANTS

Jane Kim, Coordinator
Korean Youth Center

Hwasoo Lee, Ph.D., Director
Korean-American Mental Health Service Center

Mrs. Sun, Counselor/Social Worker/Bilingual (Korean-speaking)
Mrs. Kim, Counselor/Social Worker/Bilingual (Korean-speaking)
Korean Woman Abuse Project

Dr. Myoung Hee Min, Family Planning Consultant
Koryo Health Foundation

Yvonne Wong
Chinatown Committee for Social Services, Inc.

Christina Hsu, Family Planning Consultant
Chinatown Service Center

Adele Satele, Psychatric Social Worker
Asian/Pacifc Counseling and Treatment Center

Malili Fuimatu, Samoan Interpreter
Los Angeles County Harbor/UCLA Medical Center

Joselyn Geaga Yap, Psychiatric Social Worker
Asian/Pacific Counseling and Treatment Center

Milda Rimonte, ExecutiveDirector
Oriental Service Center

Dr. Jenny Batonmailque
Private Practitioner, OB/GYN

Teresita Vasquedi, Health Planner
Health Systems Agency Los Angeles

Kogi Sayama
Administrative Assistant to Tom Bradley, Los Angeles

Sachiko Reece, Mental Health counselor, R.N.
Asian/Pacific Counseling and Treatment Center
Los Angeles County Mental Health Services

Berry Masai, Social Worker
Asian Community Service Center

Amy Mass
Japanese Psychiatrist

Ngoc Pham, Vietnamese Community Counselor
Asian Community Services Center

Nguyen Phuoc, Vietnamese Job Developer
Oriental Service Center

Manote Kongthong, Thai-speaking Social Worker
Oriental Service Center

Bibi Sayakhot, Lao Social Worker
Asian Community Service Center
Lao Job Developer
Pacific Asian Consortium in Employment

Than Pok, Camobdian Social Worker
Asian Community Service Center

Mary Arimoto, Executive Director
Asian Family Outreach

Aya Dinning, Director
Magnolia Family Planning Clinic

Carolyn Yano, Psychiatric Social Worker
Asian Rehabilitation Services

The first month of the Asian/Pacific Research Project, an additional goal was identified: to investigate special groupings within the Asian/Pacific community which were in need of special attention regarding family planning. Several other additional subgroups were to be included in the investigation. In light of this development, the Key Informant Survey also included some initial investigative/ inquiries regarding the Asian/Pacific handicapped community and Asian/Pacific women of international marriage (Asian warbrides). The main function of the survey was not to gather more statistical data, but to substantiate and fill in subjective information that statistics were unable to address.

The interview focused on identifying cultural barriers preventing Asian/Pacific women and men from being open to receiving family planning or learning about it. (See Appendix B).

PREPARATORY QUESTIONS FOR THE ASIAN WOMEN'S HEALTH PROJECT

1. What are some of the general characteristics of the _____ community?

   A. Class background, makeup
   B. Types of employment
   C. Geographic concentration
   D. Percentage of single adults
   E. Age breakdown
   F. Sex breakdown
   G. Size of family, extended family situation
   H. Level of income
   I. Length of residence
   J. Relationship to other Asians, Third World people, majority culture people
   K. Any cultural particularities
   L. Main problems or issues as a community

2. Do you feel there are cultural barriers preventing _____ women (and men) from being open to receiving, or learning about, family planning methods?

3. Do the low-income women of your community receive, or know where or how to receive, adequate health care--in particular, family planning care?

   - If not, what do you feel may be some of the barriers preventing the women from receiving this care?

   - If so, where do they receive these services?

4. How much knowledge do you feel that women from the community have regarding their health in general, and family planning in particular?

5. Is there a relationship between the amount of knowledge of health care and family planning and
   income level?
   length of residence in the Uinited States?
   age?
   sex?
   religion?
   other?

6. Are most of the women you see recent immigrants?

7. Are there community organizations and service groups in _____ community?

   - Do these organizations provide for the health needs of women, or provide anxillary services? follow up services?

The major barriers revealed, however, were institutional. The two main barriers common to all groups and already identified by past studies and substantiated by the Asian/Pacific Research Project Consumer Survey results) were the lack of bilingual/bicultural health workers of Asian/Pacific descent and the lack of health education in general. A particular aspect of the second barrier was the total lack of family planning educational materials available to Asian/Pacific peoples in languages they could understand.

The secondary focus of the questionnaire centered on obtaining further historical and demographic data on the target groups, which were unavailable through other sources. The Key Informant Survey uncovered an abundance of information and analytical material linking target group attitudes and practices regarding family planning with cultural patterns and mores from the home country, history and immigration patterns from the home country, economic background, and on and on . . . this in addition to an indication of the impact of major institutional influences such as racism, religion, etc.

Indeed, it is important to review a basic history of the Asian/Pacific peoples experience in America, and the institutional barriers that had to be overcome in order for them to settle in this country and raise families. This history is important to understand, for its impact remains. Remnants are seen today in the Little Tokyos, Chinatowns, and Manilatowns of Los Angeles County—products of the continuing lack of total acceptance into the American mainstream (the "melting pot" with very few resources available to the different ingredients making up the "melting pot")

1. History

Asians have lived in America under a constant onslaught of xenophobic attitudes. The first Asians to arrive in the United States were the Chinese, who in the mid-1800's were brought in as a cheap "slave" labor source after the emancipation of black Americans. In 1882, Congress passed the Chinese Exclusion Act limiting the immigration of Chinese to America for many years. The Japanese were then being recruited as a new source of cheap labor and, as agricultural workers, began turning land considered unworkable into farmland yielding marketable crops. In 1913, several western states passed an Alien Land Law which prevented Asians, especially Japanese, from leasing or owning land.

However, children of the immigrants born in America were not "aliens;" they were U.S. citizens with rights of U.S. citizens such as land ownership. In 1921, another act was passed which prevented children from becoming U.S. citizens if they were the offspring of "aliens" married to U.S. citizens. Finally, in 1924,, an Immigration act was passed barring the immigration of all Japanese. By this time, Pilipino workers were immigrating to Hawaii and the West Coast. In 1934, the Philippine Immigration act restricted Pilipinos coming in to 50 persons a year.

There were also laws preventing Asian women from coming into this country, as Asians were sought as cheap labor to be used, the discarded. They were not desired for their potential as American families. In addition, more laws were passed barring intermarriage with the Asian "aliens." A glaring result of this past racist legislation can be seen today in Los Angeles County in the predominantly single elderly male population in Little Tokyo, Chinatown, and Manilatown. Most of these men never had the opportunity to marry and build a family; many did not earn enough money to return home; and some felt that could not return home as a "failure back from the land of golden opportunities."

Perhaps the most infamous racist act perpetrated against a whole people was the 1942 Executive Order 9066 by President Franklin D. Roosevelt, which placed 112,000 Japanese into 10 relocation camps, also called the Japanese "concentration" camps. Two-thirds of these 112,000 Japanese were American citizens. Over $200 million worth of Japanese-American property was lost, or sold dirt cheap. A reparation suit is currently being organized to recover lost property.

During that time, the sentiments of many American people toward the Japanese were negative in trying to determine the camp sites, a naval officer advocated placing all the Japanese on Molokai, one of the Hawaiian islands which is a leper colony.[4] In 1945, Congressman Ted Johnson of Oklahoma (Dem) advocated a bill for forced sterilization of all Japanese women of childbearing age.[5]

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[4]Daniels, Roger: Concentration Camps, U.S.A. New York: Holt, Rinehart and Winston, 1971, p. 73.

[5]Bosworth, Alan: American Concentration Camps. New York: W.W. Norton

Surprisingly, little is known or recorded in history textbooks about this infamous injustice, and many Americans are surprised to learn about it.

This history has had an impact on the health (and mental health) of the Asian/Pacific people. For instance, the impact of the concentration camp experience on many Japanese Americans has been seen in much suppression resulting in chronic headaches, ulcers, insomnia, gastro-intestinal disorders, and so on. It is also not uncommon to find third-generation Japanese American do do not speak the Japanese language or understand Japanese culture. Their parents, faced with the reality of genocide of the whole Japanese race in America, tried desperately to become Americanized and have their children assimilated into the American culture as much as possible.

2. Demographic Information

Seven main questions were posed to the key informants. The questions sought out further information regarding background and cultural characteristics specific to their communities, attempted to identify institutional and cultural barriers faced by Asian/Pacifics in health and family planning; and tried to gauge the amount of health education and information needed.

The first question dealt with further background information and had a number of different components.

a. Class Background and Types of Employment

Information regarding class background and type of employment was sought to determine whether there was a definite trend showing a specific economic class immigrating to this country and constituting the specific community. If so, the next step would be to discover whether there was a correlation with health or family planning attitudes. As a result, an attempt would be made to identify specific needs or preferences. For instance, if it were found that most of the recent Korean immigrants were younger, more educated middle-income working people, outreach and education through vernacular media sources could be sufficient.

The overwhelming majority of Asian/Pacific peoples immigrating to the United States were laborers in agriculture and other industries. This was especially the case with the earlier Chinese, Japanese, and Pilipino immigrants, and the Samoan, and Guam/Pacific Island immigrants. Many of the recent Indochinese immigrants had a primarily agricultural, background, but also had fishing skills, having lived close to coastlines. There were also significant numbers of ex-military and ex-civil service personnel, and for the Vietnamese—former ministers, ambassadors, and politicians. However, the majority, being from agricultural economies, had no previous need for family planning, and therefore had very little knowledge about it. (In agrarian societies, large families are needed to work the land; hence, many children are seen as a sign of prosperity.)

Regarding employment, the Asian/Pacific community in Los Angeles County, as a whole, was a multi-class community, with a large segment working in "blue collar" jobs (e.g., as garment and textile workers, assembly line workers, restaurant and hotel workers) and in seasonal employment (e.g., as workers canneries and on farms). Korean, Chinese, Japanese, Vietnamese, Lao, Thai, Samoan, and Pilipino people (mostly recent immigrants) were in these jobs. Other lower paying occupations of significance were those as housekeepers, shipyard workers, barmaids, industrial and warehouse workers, and laundry and janitorial workers. Some occupations gave opportunity to skilled labor.

The service workers mentioned most frequently were among the Korean, Chinese, Pilipino, Samoan, Vietnamese, and Japanese communities, in the categories of clerical workers, social workers, and hospital workers such as nurse's aides.

Pilipinos and Samoans had a large population of servicemen. (Note: during the period of restricted immigration, this was one of the few avenues open to Pilipino men, who even then were restricted to kitchen duties.)

Each community had its professional class led by the Pilipinos, Japanese, Chinese, and Koreans. The nursing profession had large numbers of Pilipino, Thai, and Guamanian members. The medical profession, in general, included significant numbers of Pilipinos, Japanese, and Vietnamese. Engineers, attorneys, and accountants were also mentioned.

In addition to small businesses in the established Chinese, Japanese, and Pilipino communities, the Koreans had gained tremendously in this area, with an estimated 400 liquor stores, 200 coffee shops and stands, 70 restaurants, and a growing number of gas stations (and some massage parlors).

Large numbers of professional and technical personnel have been coming from Korea and the Philippines largely because of the restrictions limiting immigration to professionals. But the majority of Asian/Pacifics are of laboring class background, with little knowledge or exposure to the English language except among those from territories and countries with political ties to America (e.g., the Philippines, Samoa, and Guam).

b. Income Level

The income level of recent immigrants was thought to be fairly low. The average Lao family of six was surviving on $543 per month. The average working Cambodian was earning about $500 per month, $700/800 per month if both husband and wife were working. However, 20 to 30 percent of Cambodians were on welfare, and an additional 30 percent were unemployed. Samoan couples were earning $500 to $800 per month if both husband and wife were working. Incomes for second and third-generation Asian/Pacifics were generally higher. The women of international marriage (Asian warbrides) who were now single were earning very little income. The low level of income further substantiated the need for low-cost and/or subsidized health services for the Asian/Pacific communities.

c. Geographic Concentration

Most recent surveys have indicated that there are 519,000 Asian/Pacifics in Los Angeles County however, this numbers does not include the undocumented and others that census takers have missed. Neither does it account for the continuing influx of immigrants. The Los Angeles City Population, Employment, and Housing Survey indicates that the Asian/Pacific community has shot up by 68 percent in Los Angeles City in the past year (1977) alone!

Many Asian/Pacific communities are concentrated in areas near one another. The Uptown District (Eighth Street, Vermont Avenue, Crenshaw Boulevard and Olympic Boulevard and historically has had a rich mixture of Japanese, Hawaiian, Pilipino and some Chinese residents (as well as native Americans, Latinos, Greeks, ethnic Europeans, and those from the Middle East). In recent times, an estimated 80 percent of 60,000 Koreans have moved into or purchased businesses in this area. There are approximately 100 Vietnamese families here, and one of the largest concentrations of Laotians.

Long Beach is the site of another ethnically mixed area housing large communities of Pilipinos, Vietnamese, Lao, Cambodians, and Guammanisians as well as Japanese women of International Marriage (war brides). The Long Beach, Wilmington, Carson, and San Pedro areas hold the largest Pilipino and Samoan concentrations, with 16,000 Samoans estimated to be living in Carson alone.

Many Asian/Pacific people have moved to the San Fernando Valley (e.g., North-Hollywood, Burbank) including numbers of Vietnamese, Lao, Thai, Pilipinos, and Asian war brides.

Hollywood has attracted Vietnamese, Lao, and Thai, as can be confirmed by the new Vietnamese and Thai restaurants opening in that area. The Thai have been attracted by their main Buddhist Temple in Hollywood. Many Indochinese seem to reside near their temples.

Japanese and Chinese have resided in Monterey Park for a number of years, and have witnessed a recent influx of about 2,000 Koreans into the area.

A number of Cambodians and Vietnamese are now moving into, and are opening small businesses in, Los Angeles' Chinatown.

A large community of Japanese Americans and Japanese nationals live in Gardena, spilling over into Torrance. Recently, Korenans, Lao, and Asian war brides have begun moving into this area.

East Los Angeles, Boyle Heights and Lincoln Heights contain significant communites of working class and low-income Japanese and Chinese.

Second and third-generation professional Asian/Pacifics are beginning to move into outlying areas such as Cerritos (Japanese, Koreans, Pilipinos), Palos Verdes, and Orange County (Japanese, Vietnamese), and Huntington Beach.

Other heavily populated geographic communities are Little Tokyo, Temple Street area or "Manilatown" (Filipinos), the "Westside or Crenshaw area (Japanese and some Chinese), and Culver City (Japanese and some Lao).

The fact that the Asian/Pacific communities are located throughout Los Angeles County has been a main consideration in not recommending one Asian/Pacific Family Planning clinic----there would be no central location

d. Population and Age, Sex; Percentage of Single Adults

The recent immigrants had the fewest senior citizens. Most immigrants were between the ages of 20 and 40 years, and were in a better position to immigrate, establish themselves, and then send for their families. In fact, the largest Korean, Vietnamese, Lao, Cambodian, and Thai groupings were between these ages. The Korean, Pilipino, and Samoan groups had very large populations ranging from the teens through the 20's. The Japanese, Chinese, and Pilipinos had the longest residency in the United States and had sizable communities of elderly single males.

The persons interviewed felt that the male to female ratio was fairly even, with slightly more males among Chinese and Koreans, and substantially more males among Thai (66 percent male) and Cambodians (60 percent male).

The percentage of single adults was small among the Chinese about 20 to 30 percent of the Vietnamese (primarily male soldiers fill in that category, as approximately 15 percent of the Lao, and 30 percent of the Cambodians (mostly male). Pilipinos had a large number of single women of childbearning age; and the Thai had a large number of singles:---50 percent of those who came over in 1965 during the Thai student immigrant wave.

e. Family

The extended family goes beyond the nuclear family and includes grandparents, aunts and uncles, cousins, and relatives even beyond. It represents the traditional Asian/Pacific family culture, especially important in agricultural economies where every helping hand is used.

In America, the Asian/Pacific extended family may not live under one roof, but in the same area, as close by as possible. This is the case with many Pilipino families. Among traditonal Chinese, the Family Association is considered the extended family and can number in the thousands. In this case, family members are not all concentrated in the same area, but may be scattered over the nation (e.g., the Wong Family Association). The recent Chinese immigrants live in an extended family situation. The Vietnamese extended family numbers about 30 to 40 people.

The Samoan extended family ranges from between 20 and 50 up to 200. This grouping is based on the Matai system carried over from Samoa. The Matai is the chief of the extended family, and makes all the decisions of the family, whose members can number up to 200. He is looked to as an authority and ultimate decision-maker in times of grief, celebration, and emergencies. In Samoa, he was the owner of the land, but very much unlike the "rich greedy landowner" we are familiar with today. His land was not used for cash crops, but for his extended family to live on.

The Koreans, Japanese, Lao, Thai, Guamanians, Vietnamese, and Cambodians, and some Pilipinos live in nuclear families; some, because of their families are still back home; others, because years of American culture have removed them from this tradition.

The average Korean, Japanese, and second-generation Chinese family has 2 to 3 children. The average Thai family seeks two children. Middle-income Pilipino and Vietnamese families stop at three children. The average Lao family includes four children. It is normal for a Guamanian family to have four to five children, and a Cambodian family, four to six. Chinese immigrants usually have five to six children. The average Samoan family ranges from six to ten children. It is not surprising to find low-income Vietnamese and Vietnamese-Chinese families with ten to fifteen children.

f. Length of residence in the United States

The earliest wave of Asian/Pacific immigrants began in the 1860's with the Chinese, closely followed by the Japanese. Next came the Pilipinos and then the Koreans, with the majority of immigrants continuing to be Chinese and Japanese. Because of their relatively long history in this country, and because of the racist experiences they survived, the Japanese and Chinese, and to a lesser extent the Pilipinos, have the most organized community structures. They also have a sense of what it takes to survive as an Asian people in the United States, and therefore have a deep (many times subconscious and unspoken) understanding of the need for Asian American unity—joining forces to make the small minority larger and thus enable its needs and opinions to gain more attention.

World War II brought numbers of Pilipinos into the military, and in 1950 the first wave of Samoan immigration reached Hawaii and then San Francisco. The heaviest Japanese immigration began after the Korean War, and included an influx of Japanese war brides in 1960. After the revolution in China, many of the bourgeoisie fled to Taiwan and Hong Kong, and then to the United States.

In 1965, Pilipino immigration was limited to professionals only. Thai students began coming into the country at this time. About 1968, a second wave of Samoan immigration wave reached the United States; there was no quota on Samoans because they were from an American territoy. A large Korean influx took place about 1968, largely because of unrest and instability in Korea. The Korean population in Los Angeles increased from 8,500 to 104,000 in 10 years. During the early 1970's, a wave of Guamanian immigrants arrived as the result of a real estate boom in Guam which caused the local economy to boom, in turn. Guamanians used the money to move to the United States.

In 1975, the wave of Indochinese immigration began, with hundreds and thousands of displaced and fleeing Vietnamese, Cambodians, and Lao coming in as a result of the war. Pilipino immigration began to increase about 1976, with 20,000 Pilipinos a year coming in, and a premium on professionals. (This recent influx of professionals has impact on the statistics, giving a rather erroneous picture of the median economic status of Asian/Pacifics).

g. Relationships Among Asian/Pacific Peoples

Relationships between Asian/Pacific ethnic groups, between Asian/Pacifics and other Third World peoples, and between Asian/Pacifics and members of the majority American culture (Caucasians) have been shaped by the international situtation and its impact on their homelands. Contributing elements have included the impact of colonization, foreign aggression, and an Asian country's experience with imperialism as well as the influence of missionaries.

Japan, in its trend towards Western industrialization and expansion, had invaded and occupied China, Korea, and the Philippine Islands. The impact among older Chinese, Koreans, and Pilipinos, who remember this experience, is distrust and some hostility, especially among those Koreans educated in Korea in the 1930's during the Syngman Rhee regime. Likewise, some of the older Japanese feel "superior" to other Asian/Pacific groups-an attitude fostered by the Japanese militarist government at that time, as a rationale for invading and exploiting the other Asian countries. (Recent studies and reports indicate that the same type of "indoctrination" was given to U.S. servicemen before entering Vietnam). However, increased interaction in business, tourism, and other trade agreements has reduced hostilities. Among the younger third and fourth generations, there is a strong move toward Asian American unity. This trend is based on a growing recognition of the common experiences Asian/Pacifics faced historically in America, and a realization that there is strength in numbers (on agency and advocacy levels). Extensive cross-culturalization through schools, work, and other community interests also has strengthened the trend.

The Samoan community and a segment of the Pilipino community, both of whom were very active in the Asian American upsurge during the 1960's and 1970's are beginning to pull back a little. These communities, the "Brown Asians," are specifically identifying themselves as a distinct group in the Asian category: Pacific Islanders; or as a distinct category: Polynesian.

The Indochinese communities are relatively new to this country, and as yet do not share some of intense historical experiences with racism in the United States endured by the previous groups. However, their culture has many points of similarity with other Asian cultures. As natives of Indochinese countries, they share a north and south split like that of Korea, and they (especially the Vietnamese have faced major war devastation in their country, as have the Japanese. Because of their newness to this country, and their distinct language, they are very close-knit groups who, like the Cambodians, tend to have little contact outside of their communities. There are in-house differences between these communities, -some related to the changing relationship between their homelands,—but these have not become major.

It was important to identify and analyze relationships in order to understand the feasibility of different recommendations. For example, the development of one small Asian/Pacific family planning clinic has been suggested by many. The reality, however, is that at this point in time it would require large funding to adequately staff such a clinic with the various Asian/Pacific bilingual/bicultural health personnel needed.

h. Relationship to Other (Third World) Minorities

Many prejudices exist here, and these have deep historical roots. For example, there is some prejudice in the Samoan community toward blacks. This is traced back historically to the period when the Queen of England, who owned property in Samoa, brought African slaves in to work the land. The African slaves were not allowed to mix with the Samoans, go to the same stores, or live in the same areas...they were totally isolated, and discriminatory attitudes were fostered. This situation created a continuing prejudice and lack of knowledge.

The Spaniards had a similar influence during their occupation of the Philippine Islands. Their credo was the "the blacker and poorer, the more despised." Even today, when her child is born, a Pilipina mother may first ask, "Is it light-skinned or dark-skinned?" before inquiring about the baby's gender. The Spaniards also looked down on Mexicans--an attitude they passed on to Pilipinos. It is interesting to note that the food patterns of Pilipinos and Mexicans are very similar.

Older Japanese and Chinese have assumed some of the racist stereo-typed attitudes toward other Third World people that members of the majority culture hold. Also, in recent times of increased health and human service cutbacks, Third World people find themselves in positions where they feel they must compete for the same crumbs.

Among the recent immigrants, there has not been a strong bond with other Third World communities primarily because of communication problems. Some antagonisms have arisen as the result of racist stereotypes of Asians that influences other Third World groups. Also, recent immigrants are easy targets for rip-offs and the work of con artists, and since immigrants and most Third World people are confined by economic status to the same areas, the frustrations are vented on each other.

Some of those interviewed felt that the Federal Government fostered a "divide and conquer" attitude created competitiveness and pitted one group against another. The tightening up of immigration laws "because of the Mexican illegal aliens," and the tremendous cutbacks in human service funding (leaving only small amounts to be "fought over") have contributed to animosities and competition among the poor and people of the Third World.

The younger generations, however, are intermingling and intermarrying more. Their attitudes are open and are based more on one another's principles and practices than on the color of their skin. In fact, a number of Third World and minority coalitions are forming around health cutbacks, Proposition 13 cutbacks, and issues such as the Bakke Decision.

i. Relationship to Anglos

The majority of persons interviewed felt that their community thought of the United States as a "white" country. They considered whites "structurally superior" (i.e., holding leading positions in basic institutions of this country such as government, the judiciary, communications media, and education), and continued to refer to their homeland as "home".

The attitudes were mixed; some were made to feel inferior to whites' some were intimidated by language problems and suffered from cultural shock, and many felt distrust. Sometimes all these feeling were mixed with admiration. For some communities, white were the models of success and the Asian/Pacifics were making great efforts to become assimilated and "make it." Some felt that marrying a white was an achievement; but many, although they may have looked up to whites, wanted their children to marry within their own nationality. Many of the recent refugees from Indochina saw whites as friends who helped them flee from their country and into the United States.

j. Specific Cultural Characteristics

All Asian/Pacific cultures traditionally have a very high regard for elders. In some cultures (e.g., the Japanese) it is rude to make direct eye contact. Americans often mistake this for excessive shyness.

Almost all Asian/Pacific people have experienced some form of colonization by Western powers, with a resulting "colonization mentality." Some manifestations may be seen in Pilipinos, for example, who were colonized for 400 years by Spain and the United States, and who now have taken on many of the prejudices and stereotyped attitudes toward other Third World people that the colonizers had, and have adopted the value system of seeing lighter-skinned people as better, and feeling inferior for having darker skin. Other manifestations can be seen in the Japanese and Korean women who have had eye operation performed to make their eyelids doubled and more anglicized. Many times, Asian/Pacifics parents have been intimidated by the racism of this country to the point where they have not passed on their culture to their children. The result has been that many Asian/Pacifics from their teens through thirties may be undergoing identity crises. There are numerous other examples, such as the second-generation Japanese who have gone through the relocation or "concentration" camp experience during World War II and tend to be "workaholics," developing a high incidence of high blood pressure in their efforts to ensure that such an occurrence will not be repeated for their people.

Extreme male dominance is another trait common to almost all Asian/Pacific communities. Much of this stems from the old Confucian Philosophy which relegated women to the lowest position. There are many instances in which the husband has passed away, leaving a wife who had been so dependent upon him that she is unable to even balance a checkbook, drive, or make important decisions about health care. In some cultures, the women are extremely protected. For example, in some very traditional Pilipino families dating is taboo, or if allowed, the woman is accompanied everywhere by a chaperone. Samoans and Guamanians are encouraged to marry early, when about 18 to 23 years old. There is no formal dating system, and premarital sex is prohibited. There is very little open affection. In Cambodia, where there is a shorter life span, women marry very young. In a number of recent cases in Long Beach, Cambodian men in their thirties have married 12-, 13-, and 14 year-old girls.

Children are very important to Asian/Pacifics. They are looked upon as bringing joy and prosperity,--a logical attitude in an agricultural economy where large families are needed to work the land. In many cultures, birth control is not desired at all.

A sense of family is very important to Asian/Pacific peoples, and the family roles are very strong. The clash of new ideas, and radical cultural differences in America, created havoc in many immigrant families, with the resultant need for more mental heath counseling and other services, especially in family planning and sex education.

Recent histories of the various homelands have delineated cultural particularities. Korean women were described as rebellious, mobile, and aggressive because of having lived in a country that has experienced several major upheavals within the last three decades. The rapid industrialization of Meiji Japan has resulted in many Japanese women trying to be more like white western women, and therefore being more open to family planning.

Asian/Pacific countries that have been occupied by citizens of other countries, have people with a mixed culture (e.g., the Vietnamese, who have French and Chinese cultures; Filipinos, who have Spanish and Japanese blood; Koreans who speak Japanese fluently).

Countries which have not gone through a modernization process and whose communications system is not as advanced as that of the United States, for example, have different regions with very specific languages, dialects, physical characteristics, and cultural habits. Some examples are the Lao (city) and the Hmong (Lao countryside) languages and the hundreds of dialects in China.

3. Cultural and Institutional Barriers

The interviews with key persons providing direct services (e.g., community and social workers) revealed general information about the various Asian/Pacific communities, and the impact or influence certain factors have had on family planning. Summarizing past work with Asian/Pacific women, and viewing the meager data available on Asian/Pacific women and family planning made it apparent that significant institutional and cultural barriers were contributing to the under-utilization of family planning services. It was deemed important to identify these barriers in order to develop a workable family planning service delivery model that could address many of these problems.

The main barrier centered around language. There were almost no health and family planning facilities that had equipped themselves to handle the specific language and cultural needs of the Asian/Pacific community. In fact, there were practically no bilingual/bicultural Asian/Pacific health workers in the field of family planning. For many of the smaller Asian/Pacific communities, there were NO bilingual/bicultural health workers. The few non-English-speaking Asian/Pacific women who were receiving services (outside of Chinese, Korean, and Japanese women) were accompanied by their social worker or a translator. In Asian/Pacific communities that have only one social worker or community worker of their ethnic background the burden becomes too great for one person to handle. In these situations, the social worker must carry on translations by telephone with the doctor or women's health care specialist. This method of interpreting does not allow for in-depth explanations.

The second barrier common to all groups was the minimal or nonexistent health education about preventive health care and health practices in general, and family planning in particular. The materials were not available in their native language. In addition, because of the specific cultural traits of Asian/Pacific women, most of the existing health education material would have to be reworked to be more acceptable and understandable to these women. Most of the family planning information the women were receiving was through hearsay or word of mouth from friends and relatives.

Religion presented another major institutional barrier for many Asian/Pacific people. The Catholic massionaries traveled throughout many Asian/Pacific countries. It was estimated that 80 percent of both Guamanians and Pilipinos in Los Angeles County were Catholic. (Some distinction was made between "practicing" and "non-practicing" Catholics). For many Asian/Pacific communities, the result has been seen in many taboos and in confusion, guilt, and fear about family planning, abortions, premarital sex, and sex in general. For example, abortions are illegal in Guam unless the pregnancy is endangering the life of the mother. In some cultures, family planning and related subjects are not supposed to be openly discussed-a situation that contributes to misinformation and hearsay methods of health and sex education. As another example, in Laos, celibate Buddhist monks taught birth control to married couples--not a very strong testimony to theory and practice!

Modesty and the feeling of being uncomfortable with men, especially white male doctors, create an environment of cultural inhibitions and embarrassment not only in seeking family planning health care, but in receiving gynecological examinations. Many Asian cultures are traditionally internal (i.e., they emphasize stoicism, handling one's problems oneself), and "opening up" is generally difficult, especially with strangers. For many Asian/Pacific women, it is extremely difficult to openly discuss areas considered taboo, and to permit a physical examination. The fact that most of the doctors or health workers are non-Asian and non-bilingual/ bicultural, makes seeking family planning a real ordeal, something undesirable and easier left undone.

A strong Confucian influence still dominates or affects most of the East Asian cultures. Confucious taught that women had a very limited and lowly role in life. He taught that when a woman is born, she is subservient to her father; when she marries, she is subservient to her husband; and when he dies, she is subservient to her son. In feudal China, men from the upper classes would ejaculate on the ground rather than waste their sperm on a woman; also, for a time many of the elite would develop homosexual relationships with young boys or other men, for it was felt that full sexual enjoyment could only be achieved with another man, one's equal. Although these practices were primarily among the elite, the ideology itself had a heavy impact on the peasants and "lower classes." This retrogressive philosophy still contaminates Asian cultures and has a significant impact on family planning practices.

In the cultures of many immigrants, the man dictates what methods of birth control the woman shall use, or whether she can use a birth control method. Some women are pressured to continue bearing children until a boychild was born. In some cultures, it is felt that women are solely responsible for the gender of the child. Parents of Asian handicapped infants sometimes continue to give birth to physically or mentally handicapped children because the mother is so guilt-ridden about not giving birth to a normal child that she wants to continue trying, so that she can redeem herself. And it is not uncommon for an Asian/Pacific man to have no idea about the type of birth control method his wife or partner is using. It is very apparent that family planning information is critically needed for both Asian/Pacific men and women.

The roles for women are sharply defined in most Asian/Pacific cultures, with the man being breadwinner and decision-maker. New immigrants, however, find that it is sometimes difficult for a non-English-speaking male to find work, or that the pay is so low that both husband and wife must work. The result is that women are becoming more independent and are learning more. Since at least half of the breadwinning is theirs, they are taking part in much of the decisionmaking. The culture shock of having women become breadwinners, and the new equality within the family, have created an upheaval in the Asian/Pacific family, with some distrastrous results (e.g., a number of wife-abuse programs are developing; the divorce rate is rising; mental health services are being required more and more). On the positive side are an emerging recognition and respect for the women as an equal and talented partner, and more self-confidence and independence on the part of women.

Lack of finances present another important deterrent to health care delivery. Many recent Asian/Pacific immigrants cannot afford health care, and they don't know where to go to get low-cost services because there is no outreach to their community or in their language. Many Asian/Pacific people don't seek preventive health care, or are not conscientious about getting checkups. A large factor in this problem is that many were brought up within an impoverished environment where one never saw a doctor unless it was a crisis, life-or-death situation. Subconsciously, many Asian/Pacifics still carry that attitude.

Clinic hours are not convenient for many Asian/Pacific women. Many low-cost clinics are open only during working hours, and therefore are not available to working women. Most clinics do not have child care areas, and it is difficult for mothers to bring their children with them. Long waits make it even more difficult to take children along, and it is too expensive if one has to pay for a babysitter. Some women reported having to spend from 3 to 6 hours in one clinic visit.

Transportation is another problem. Many people do not have cars, and are unfamiliar with the bus system and the layout of the city. In addition, all the street signs and maps are in English. This situation creates a real problem, for one must sometimes travel a substantial distance to reach a clinic where there is an Asian/Pacific health worker who speaks the patient's language (such staff members being few in number).

There is an appalling lack of outreach and information on the part of health agencies and clinics located near or within Asian/Pacific communities. Clinics that offer low-cost services do not place enough emphasis on outreach, especially outreach to the Asian/Pacific communities. What little material there is, is not translated into Asian/Pacific languages.

As mentioned previously, in most Asian/Pacific cultures children are looked upon as a joy, and birth control or family planning is not desired. Not only health education but a basic re-orientation to living in the United States is necessary ("acculturation" classes), to explain the difference between having 10 children in an extended family setting in the countryside of Vietnam (where childcare is no problem and where every helping hand is welcome) and having 8 to 10 children in Los Angeles, with its soaring unemployment and lack of good opportunities for immigrants.

The family is going through an upheaval. There is a clash between old traditional ways and the "new" American ways. Sometimes the culture shock and the ensuing struggle between old and young result in teen runaways. The strict traditions surrounding "dating" are quite different from America's standards, creating conflicts within both parent and child. Disciplinary measures taken by parents are sometimes interpreted by Americans as constituting "child abuse." In a recent case, a Vietnamese father was reported by a neighbor and was arrested by police without his even knowing that the charges were or being able to defend himself. There was no Vietnamese interpreter with the police.

Asian Women Health Project

Immigrant women from countries such as Japan and Korea, that have gone through rapid industrialization and modernization, are much more knowledgeable and open to family planning. Birth control methods and their use are openly written about—with illustrations—in Japanese magazines, and family planning is advertised in the Korean vernacular press in Los Angeles.

The Asian Women's Health Project was able only to scratch the surface of the immense barriers to family planning faced by the Asian handicapped community. Handicapped people in general face very special problems, and being Asian and handicapped is being in double jeopardy. The Asian handicapped women are very sheltered and much overprotected by their parents. Among the physically handicapped, the men are eventually encouraged to get work, join sheltered workshops, or take part in other programs; but the women are not encouraged to go out and face the world. Drugs are frequently given to the mentally handicapped to suppress sexuality. There is absolutely no curriculum for sex education for the mentally or physically handicapped. There is no peer group education, because none of their peers have had any sex education either. One mentally handicapped woman was never taught about her menstrual cycle, and each month menstruation becomes a harrowing experience for her. There are many new and innovative ideas regarding a sex education curriculum for the handicapped, but old conservatism or lack of interest on the part of funders has prevented any major breakthroughs in this area. The Asian/Pacific Research Project felt that this was an important concern.

War also impacts on family planning. A heavy influx of war brides took place in the 1950's after the Korean War. Now most of the children from these marriages are of dating age and are sexually mature. Conflicts between mother and child around traditional values and American values are even more intensified because the child is a product of two cultures, physically as well as emotionally. Many of these conflicts center around such issues as sex, dating, and family planning, creating teen runaway situations and other forms of rebellion.

Even politics has an impact on family planning. For example, the Chinese community in Los Angeles is lined up according to the international situation in China, with a strong pro-People's Republic of China camp, and a strong pro-Taiwanese group. Chairman Mao Tse-tung's teaching on family planning define it as a way to raise the standard and quality of living. This has a positive influence on the attitudes of some Chinese women toward family planning.

The majority of women did not know where to go to receive adequate health or family planning care. Those who did, said they heard of low-cost health facilities through relatives, the church, or newpapers (Korean). The clinics from which they sought help were Koryo (a Korean clinic), White Memorial Hospital (East Los Angeles, Boyle Heights), California Hospital (near Chinatown), and T.H.E. Clinic for Women. Some of the women went to private doctors or the closest hospital or clinic.

Most of the respondents felt that the women in their community needed more knowledge about health. Preventive health care was still a battle for Pilipina women; in fact, many did not have knowledge about their periods and ovulation. Korean women were thought to have basic knowledge but not much information beyond that. Unmarried Chinese women had very little exposure to this information. Japanese war brides had a strong need for education in this regard, as did Vietnamese, Cambodian, Guamanian, Laotian, and Samoan women. Handicapped Asian women had practically no information.

Thai women were thought to have an average amount of information. Korean women who had received their college education in Korea had a higher degree of consciousness regarding health care and family planning because of women's instruction programs and women's magazines. Many pro-Peoples' Republic of China women had a higher degree of consciousness because of the family planning slogan of Chairman Mao Tse-tung. Japanese women had a tendency to buy medicine on their own from drugstores, and avoided seeing doctors until emergencies arose.

Over one-half of the respondents felt that there was a relationship between the level of income (and education) and the amount of knowledge about health and family planning. It was generally felt that higher income levels offered more opportunities to seek out and become exposed to health education.

Among those who responded, it was felt that people who had resided in the United States longer and had more exposure to media and societal values, had more knowledge in regard to health and family planning.

One person felt that older Chinese women had more knowledge, especially in regard to family planning; but most felt that the younger generation had more exposure and education. The communities were divided as to whether women or men had more knowledge of the subject but as one Samoan person put it, "The ignorance is equal."

Well over 50 percent of those interviewed worked primarily with recent immigrants.

4. Summary of Findings

The main findings of the Key Informant Survey contributed to the overwhelming evidence of Asian/Pacific under-utilization of family planning services. Thirteen significant barriers were identified; language problems, lack of health education, religion, modesty, Confucian influences, changing roles within the family, finances, difficult clinic hours, transportation problems, lack of outreach, attitudes toward the joy of having children, culture shock, and specific problems were faced by Asian/Pacific handicapped.

Two main barriers contributing to the under-utilization of family planning services were mentioned by all those interviewed' (1) the lack of bilingual/bicultural health workers of Asian/Pacific descent, and (2) the lack of health education materials available to the community in the language of the people. The Consumer Survey supported these findings.

B. Information and Referral Review

Family planning clinics at 11 LARFPC agencies were surveyed between May 18, 1978, and October 13, 1978;

Agencies:

Los Angeles County Hospitals
Harbor/UCLA Medical Center
John Wesley County Hospital

Private Hospitals:

California Hospital Medical Center
Cedars-Sinai Medical Center

Community Programs:

Chinatown Service Center
Koryo Health Foundation
T.H.E. Clinic-For Women, Inc.

Family Planning Corporations:

Mar Vista Planned Parenthood
Planned Parenthood World Population/Los Angeles

Los Angeles County Clinics:

Southwest Health District Clinic
Hollywood-Wilshire Health District Clinic

(See Apendix C, the Survey Questionnaire; and Apendix D listing of the facilities, administrators, and practitioners surveyed).

These agencies were chosen for several reasons. First, they are in areas with a high concentration of Asian/Pacifics, or are near Asian/Pacific communities. Second, they serve large numbers of Asian/Pacific women. And third, they expressed their willingness to cooperate with the survey.

In all, 8 administrators and 12 practitioners from the 11 agencies were surveyed. The surveys took the form of person-to-person interviews held by appointment at the respective agencies. Several of the administrators and practitioners did not answer all of the questions in the survey; hence, the total number of responses does not always equal 20.

The objectives of the agency survey were threefold:

- To investigate specific information that the project had identified regarding the need for Asian/Pacific bilingual family planning workers and family planning materials; and to identify specific family planning needs of Asian/Pacific women.

- To increase the awareness of administrators and practitioners toward Asian/Pacific women and their need for family planning services. The survey could be used as a tool for this.

- To gain insight into feedback from administrators and practitioners regarding Asian/Pacific women.

1. Survey Data

There was a surprising under-utilization rate of less than 1 percent in most of the facilities. An estimated 7.38 percent of the population in Los Angeles is composed of Asian/Pacifics, approximately half of whom are female. Therefore, approximately 3.69 percent of the County's residents are Asian/Pacific females. Many of these women are not receiving family planning services.

Only three agencies had done a demographic survey or needs assessment of their general service area. Several of the LARFPC agency administrators and practitioners were not even aware of their surrounding ethnic communities, because of their patient loads of Asian/Pacific persons were so low. When they were aware of the Asian/Pacific communities, they were not adequately serving them.

The following are of the specific family planning needs of the Asian/Pacific community perceived by administrators and practitioners:

- Language and translation services for Asian/Pacific women.

- Information regarding family planning services and facilities in proximity to Asian/Pacific communities.

- Increased health education outreach efforts for Asian/Pacific women and their respective communities.

Eleven of the twenty persons surveyed were aware of an Asian/Pacific community in their general service area. Those mentioned were the following:

Area	Ethnic Group
Chinatown	Chinese
Gardena/Torrance	Japanese
Southwest Health District	Japanese and Korean
Santa Monica	Japanese
Mar Vista/Culver City	Japanese
Carson	Samoan and Pilipino
Olympic Blvd. Area	Korean
Hollywood-Wilshire Health District	Korean, Pilipino, Samoan, and Vietnamese
Central Health District	Chinese, Japanese, Pilipino, and Southeast Asians

The women demonstrating the greatest need for family planning were the newly immigrated group. Chinese, Korean, Vietnamese, and Thai women were mentioned most often as women in need of family planning services. The age groups most frequently mentioned were those of 19 to 24 years and 25 to 34 years. The focus on these age groups is understandable, as women in these groups tend to be more sexually active and more likely to need birth control devices.

Fifty per cent of those interviewed felt that transportation was a problem for Asian/Pacific women in receiving family planning services. Amazingly enough, 95 percent of the agencies surveyed were within a one or two-block radius of public transportation (e.g., buses). So it seems that Asian/Pacific women, especially non-English-speaking women, do not have equal access to public transportation because of their English language barrier. It would follow, that if these women could not use public transportation, they probably would not know how to use a health facility, because of their language barrier.

Half of those surveyed felt that inaccessibility to their family planning facility was a barrier. Seventy-five percent felt that lack of awareness of available services was a barrier.

Koryo Health Foundation was the only agency with Asian/Pacific bilingual signs regarding family planning services. The other facilities had no Asian/Pacific bilingual signs identifying their family planning services. When asked how Asian/Pacific women found out about their particular family planning facility, 60 percent stated that the Asian/Pacific woman was referred by word of mouth. The remainder found out about the family planning facility by two other means:

practitioner went on to state that he would even answer regarding the date of his wife's last menstrual period. Sometimes women wanted their husbands present during the exam. This was sometimes due to the language barrier, and the husband served as translator.

Most of the practitioners felt that the husband hindered his wife's spontaneity. They felt that as soon as the husband left the room, the woman began to "open up."

Several practitioners noticed an increased need for privacy and confidentiality. For example, Asian/Pacific women were embarrassed about carrying their urine specimens across the waiting room and leaving them at the front desk, uncovered and exposed for anyone to see. There was reluctance to talk about sexuality, sex practice, and gynecological problems. The women were embarrassed about being unclothed during the pelvic exam.

There was a distinct difference between Asian/Pacific immigrant women and Asian/Pacific women born and raised in the United States. Crystal Span, family planning coordinator of the Mar Vista Planned Parenthood, stated that "Asian/Pacific women are very knowledgeable regarding family planning, birth control, and their bodies. They are responsible patients." She went on to say that the majority of Asian/Pacific clients were second-, third-, and fourth-generation Americans, that language was not a problem, and that culture did not present a strong barrier for them.

Dr. Cheung, a family planning practitioner at California Hospital, stated that "Asian/Pacific women have no barrier to family planning." He felt there were "no reasons why Asian/Pacific women do not seek out family planning services. Most women do not feel family planning is important. And, if it does not suit the woman's convenience to go, she will not go." He elaborated on some traditional Chinese values which have an influence on family planning: desire for a large family, male preference for children, the idea that getting pregnant is normal and accepted, the fact that family planning is not looked upon as a problem, and the attitude that if women do get pregnant, they can always abort.

One practitioner stated that Asian/Pacific women need a counselor who can talk to the patient in her own language and not through an intepreter. Too much is lost in translation, and the feeling level is often squelched in the process of translating words from one language to another.

Dr. Bernstein of Cedars-Sinai family planning clinic observed that Asian/Pacific women were more reserved and "rarely asked for paid medication; rarely cried, yelled, screamed, or complained during procedures; were more hesitant to touch themselves; were less apt to ask questions.", she also observed that "their partners were more helpful."

Chris Ichikawa, a former practitioner at Harbor General Hospital, felt that family planning literature such as that provided for the Spanish-speaking clients should also be available in Asian/Pacific languages for the Asian/Pacific client. Dr. Min and Dr. Han of Koryo both agreed with this statement regarding the need for more Asian/Pacific bilingual materials on family planning and health education.

Dr. Min of Koryo stated that "many women come from Korea with a preconceived notion about family planning. They have already made up their minds about the type of birth control method they want, without hearing about all the methods. The women believes outside, nonscientific information from nonscientific sources or from friends and relatives. Even after the clinic has explained all the birth control methods, the woman many times still stays with the same birth control method because of the influence of friends and family. Middle aged to older aged women present the greatest cultural barriers to family planning. The younger women have grown up with family planning, and therefore the barriers are not as insurmountable."

Dr. Han, also of Koryo, stated that the majority of childbearing immigrant women were economically underprivileged and not fluent in English; therefore the language barrier presented a major difficulty, she also stated that they were very hard working. "These women realize the fact that they must limit the number of children until they are more economically settled. Many times these women do not know where to seek family planning services, however." She went on to say that they receive many referrals after abortion, after delivery, and after pregnancy testing; but " it takes much motivation for these women to use a birth control method, as they rely heavily on abortion if they have an unplanned pregnancy."

85% of practitioners and administrators felt that language was a barrier to family planning services. Dr. Choi stated that "complete care depends on an accurate patient history, expression, and understanding of symptoms." If the communication gap is not bridged, the patient is unable to provide the necessary information, and good medical care is difficult, if not impossible to provide. Several practitioners stated that it was difficult to provide quality care when a language barrier existed.

It is surprising that 85% felt that language was a barrier to family planning services; yet when the number of Asian/Pacific bilingual staff members was considered, very few were found to be working within the family planning clinics. The languages available were Japanese, Filipino, Korean, Cantonese, and Mandarin. No Southeast Asian languages such as Vietnamese, Lao, Thai, or Cambodian were available.

Koryo Health Foundation was the only facility with bilingual consent forms available in Korean. No other facility had any available. Half of the agencies had a system of referral if they were unable to take care of a non-English-speaking Asian/ Pacific woman.

Several of the referral sources were as follows:

1. In-house sources in other departments (i.e., lab, pharmacy, nursing service)
2. Other LARFPC clinics
3. Arrangement for the patient to return with a translator, i.e., husband or friend) for another appointment

4. An Asian/Pacific community organization or agency

5. Phone company bilingual staff, available during working hours.

80% of the administrators and practitioners stated that no dictionary with key Asian/Pacific medical terms was available. This question was asked in the survey to learn whether there was a need for such a communication tool. Over half of those questioned stated that such a dictionary would be useful for their family planning facility. Those who felt there was no need for a dictionary stated reasons such as the lack of a sufficient number of Asian/Pacific patients to warrant its use, and lack of motivation on the part of the staff to use such a tool.

Over half of those interviewed were unaware of any bilingual literature regarding health education information or Asian/Pacific family planning. During the course of the survey, some examples of such material were identified, namely, several pamphlets in Korean, Japanese, and Chinese, published by the American Cancer Society regarding the self breast examination; a birth control pamphlet in Chinese from the Chinatown Service Center; and a birth control handbook in Korean from Koryo Health Foundation.

75% of those taking part in the survey felt that cost was not a barrier to family planning services; yet many Asian/Pacific women perceive the cost of birth control and family planning services as much more expensive than they actually are. Also, many Asian/Pacific women fear accepting welfare, social service, or "free" services. They think it will affect or endanger their immigration status in some way. In addition, it was found that many Asian/Pacific women were not aware of these subsidized family planning services.

65% of the participants in the survey felt that lack of knowledge about family planning was a barrier. The majority of administrators and practitioners felt that Asian/Pacific women did not know much about family planning, but that neither did the general public, for that matter. Christina Hsu, of the Chinatown Service Center, stated that through enlarged outreach efforts, women's knowledge was being increased regarding birth control and family planning.

80% of those interviewed felt that special family planning educational programs were needed for Asian/Pacific women. Crystal Span, of Mar Vista Planned Parenthood stated, "I know that there is a population, i.e., Vietnamese, Thai, and Southeast Asian, that the clinic is not reaching. They could use this special attention." One practitioner said "Asian women would feel more comfortable, and the level of openness would increase, if there were a specific program geared especially for them."

Suggestions for special attempts useful in increasing Asian/Pacific awareness of family planning were as follows:

- <u>Outreach</u>

- Make contacts through women's clubs, schools, churches, community and agencies, and Asian/Pacific stores.

- YMCA's, YWCA's, and teen posts to reach Asian/Pacific teens.
- Use the media approach, (i.e., TV, radio, newspapers).
- Disseminate information via flyers at Asian/Pacific gatherings, festivals, and carnivals.

The outreach should be made by a person who is of the Asian/Pacific culture or a similar background who has worked with Asian/Pacific people, is acceptable to the community, and relates well to their family planning problems and life situations.

- Education

  Increase practitioners knowledge and awareness of Asian/Pacific culture and health care providers'.

- Written Materials and Information in Asian/Pacific Languages
  - Provide pamphlets regarding all birth control methods.
  - Provide one general information pamphlet on women's reproductive anatomy and physiology.

60% of the survey participants felt that Asian/Pacific women were not knowledgeable about various preventive screening tests such as the pap smear, venereal disease screening, and the breast self-examination. It was felt that Asian/Pacific women born and raised in the United States were generally more knowledgeable and aware of preventive screening tests than Asian/Pacific immigrant women.

Dr. Han of Koryo Health Foundation stated, "Women seem to know about cancer and have a tremendous fear of cancer. They go for cancer (pap smear) screening not because of knowledge of preventive screening tests but because of their increased fear of cancer." Dr. Min of Koryo felt that women are very concerned about pap smears; however, veneral disease screening is not done on a routine basis anymore at Koryo. The incidence was so low, that the testing was dropped as a routine screening examination.

75% of the survey participants felt that the Asian/Pacific women lacked knowledge and experience in using family planning facilities. Many times, the size of the health institution was intimidating to newly immigrated Asian/Pacific women. One administrator stated that the United States hospital system was a barrier to anyone, Asian/Pacific women are oriented toward Eastern medicine, and when they arrive in the United States they are faced with a totally unfamiliar health care system.

65% of the administrators and practitioners felt that all the barriers were not just specific to Asian/Pacific women, but could be applied to other non-English-speaking immigrant women. There were many parallels with Spanish-speaking women.

45% of those interviewed stated they had plans for improving family planning services to Asian/Pacific women. Several felt that continued involvement with the Asian Women's Health Project would be one way. Others felt their efforts would be focused on more outreach to Asian/Pacific women and communities. Still others felt that their efforts would be focused on all women, not just Asian/Pacific women.

70% of the administrators and practitioners desired some assistance in outreach to Asian/Pacific women through the Asian/Pacific Health Project. Requested information, materials, and services included the following:

- Information on location of concentrations of Asian/Pacific women.
- Asian/Pacific bilingual family planning brochures.
- Asian/Pacific bilingual family planning films or film loops.
- The Asian/Pacific bilingual family planning dictionary with key medical terms.
- Specific suggestions to help make Asian/Pacific women more comfortable as recipients of family planning services.
- Help in identifying bilingual staff for outreach efforts.
- List of Asian/Pacific organizations, agencies, and persons for referral or telephone translations.

When asked how LARFPC could reach out to Asian/Pacific women, the following suggestions were offered:

- Disseminate to LARFPC clinics the information collected from the Asian Women's Health Project.
- Make a list of all bilingual LARFPC staff and the clinics at which they work, for future referral.
- Hold a LARFPC-sponsored cultural sensitivity training session on Asian/Pacific women (see attachment XII).
- Contact key persons in the Asian/Pacific community for suggestions, direction, and support in these matters of outreach.
- Develop special Asian/Pacific bilingual family planning material.
- Develop a pool of Asian/Pacific translators.
- Develop an Asian-language-Speaking Council similar to the Spanish-Speaking Council.

- Hire Asian/Pacific bilingual staff in areas with high concentration of Asian/Pacific peoples, or at locations near Asian/Pacific communities.
- Develop a bilingual referral system.
- Contact Asian/Pacific women in more nontraditional forms of outreach, i.e., in church or community settings.

35% of these surveyed were interested in an in-service session for their staff regarding Asian/Pacific cultures and communities. 35% had not held an inservice session on the Asian/Pacific client. Those who felt they did not need such a session were those who had small numbers of Asian/Pacific clients. Again, the vicious cycle became apparent: when an agency does not want an in-service session on Asian/Pacific women staff members remain unaware of many of women's cultural particularities. Consequently the Asian/Pacific women who do use the agency's facility may not feel comfortable, and may not return for their next appointment.

Only 15% of survey participants had any contact with Asian/Pacific women's groups or their community organizations. Agencies mentioned were the following: Oriental Service Center, Asian Community Services Center, Asian American Drug Abuse Program, Asian Rehabilitation Services, Asian American Mental Health Training Center, Korean American Mental Health Services Center, Korean American Social Worker's Association, Pacific Asian Mental Health Services Center, Chinatown Service Center, and Korean Women's Association.

Half of those surveyed had not attempted to recruit Asian/Pacific bilingual staff members because of the low utilization of services by Asian/Pacific clients. Some felt that there was no need for a bilingual staff person; others had no funds to hire more staff persons; and other programs were geared mainly toward the Spanishspeaking client. The agencies which did attempt to recruit Asian/Pacific bilingual staff had asked other Asian/Pacific clients for referrals , had called the Women's Career Program, had advertised in the Los Angeles Times, and had posted job offers at colleges near their facilities.

One administrator suggested the community education concept, according to which outreach is carried on in the home or in the community, rather than at the clinic site. She felt that this would probably be the best method of approach for the Asian/Pacific client. However, it was not very cost-effective.

40% of the survey participants felt that it would be valuable to hold a special Asian/Pacific clinic. The majority of those who agreed with the concept, however, qualified their statements with the opinion that it would be a good idea if the need were demonstrated, if the population were larger, if there were adequate staffing, and if there were a community health worker and outreach worker who could conduct the effort. With all of these qualifications, it seems that few, if any, of the clinics will be having special clinical sessions specifically geared toward Asian/Pacific women.

One recommendation made by a practitioner was that family planning services for Asian/Pacific women need to be carried on in smaller branch offices with suburban locales. Asian/Pacific women are provincial and tend to prefer decentralized services that are more personal than those received in an urban setting. Because of the personal nature of family planning, Asian/Pacific women tend to go to a private practitioner or known ethnic health center such as Koryo.

Asian/Pacific women should be informed that free or subsidized family planning services do not mean second-rate health care. Low-income Asian/Pacific women should have equal access to subsidized family planning services.

Some Asian/Pacific women use abortion as a form of birth control. If a woman was not using any form of birth control methods and becomes pregnant, she might freely seek to surgically terminate her pregnancy through abortion. Dr. Han of Koryo stated "Koryo does a fair amount sterilization; however Korean men and women are more reluctant to go through sterilization." In terms of sterilization, Koreans are culturally similiar to Spanish-speaking persons. Three basic reasons inhibit Koreans from going through a sterilization procedure:

- They feel it interferes with their sexuality.
- They are extremely fearful of the surgical procedure.
- Culturally, they feel they do not want to lose their ability to conceive.

One practitioner felt that there should be one Asian/Pacific clinic to which all Asian/Pacific women could be referred instead of scattered clinics all around Los Angeles. This would be impractical, as Asian/Pacific communities are scattered all through Los Angeles.

A viable recommendation made by one of the practitioners was to reach out through other types of clinics and departments. Tuberculosis and immunization clinics have large numbers of Asian/Pacific patients who use these services. Asian/Pacifics would be referred through other clinics and would also become informed of other services such as family planning while they were within the health system.

One specific problem Koryo faces is followup. Once a woman has been reached, it is hard to re-motivate her to return to the clinic for followup. Koryo has difficulty motivating and encouraging women to return. Immigrant Asian/Pacific women who are oriented toward Eastern medicine may not understand the concept of followup. Asian/Pacific Americans who are more familiar with family planning services, and who are oriented toward Western medicine, will more readily return to the clinic for a followup exam.

One practitioner stated,"Going through this questionnaire and feeling like I didn't really know the answers to many questions has made me aware of the fact that I must be out of touch with the Asian/Pacific community and the concerns of Asian/Pacific women."

The survey of practitioners and administrators from 11 LARFPC agencies substantiated the under-utilization of family planning services by Asian/Pacific women.

The following barriers to family planning were identified:

- Language difficulties.
- Inaccessibility of a clinic, due to transportation problems lack of bilingual staff members, and absence of bilingual signs.
- Cultural differences.
- Lack of knowledge re: family planning.

In comparison with the average LARFPC patient, Asian/Pacific women were found to have some specific characteristics, as follows:

- More hesitancy about receiving services, resulting from embarrassment about the personal nature of the service.
- More reluctance to talk openly about sexuality and gynecological problems.
- Increased need for privacy and confidentiality during the examination, greater degree of shyness, embarrassment, and modesty, with a resulting greater difficulty in examination.
- Greater tendency to associate subsidized services with charity or second-health care.
- More hesitancy about touching themselves (i.e.,) performing a self-examination of the breast).
- Greater ability to endure pain with a resulting tendency to cover up physical symptoms and delay seeking medical attention.

Exhibit 3 presents the findings of the survey in chart form.

In conclusion, the under-utilization of family planning services by the Asian/Pacific community was again substantiated by administrators and practitioners from hospitals and clinics located within Asian/Pacific communities or in proximity to them. Major reasons cited were a lack of bilingual, bicultural health personnel; a lack of translated materials; and a critical need for bilingual/bicultural health education and outreach.

Another concern identified through the survey was the need for some form of "cultural sensitivity and education regarding the Asian/Pacific community," for administrators and practitioners in family planning facilities within or near Asian/Pacific communities. Some persuasion will be needed in this regard. For instance, the

ASIAN PACIFIC WOMEN:
cultural aspects of family planning

9:00 INTRODUCTION TO THE ASIAN WOMEN'S HEALTH PROJECT
Given by Linda Miya Iwataki and Teresa Takaki Matsushima, Asian Women's Health Project staff

Background of Asian Women's Health Project, special problems and concerns of Asian/Pacific people
Project Information - Intent, funding, methodology, staff, task force
Family planning in Asian and Pacific Island countries
Demographic and health-related information of Asian/Pacifics in L.A. County
Characteristics of Asian/Pacific women and the Asian/Pacific community
Cultural and institutional barriers in family planning
Project recommendations

10:30 ASIAN/PACIFIC BICULTURAL PANEL
* Observations and analysis of attitudes and practice of family planning by Asian/Pacific communities
* Further family planning and general health needs of the Asian/Pacific people

EXHIBIT 2

FIRST BICULTURAL PANEL:

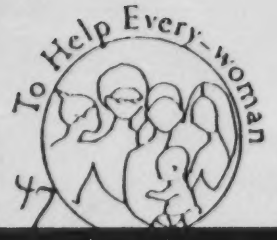
Malili Fuamatu	Samoan Interpretor, Interpretor's Unit, Harbor General Hospital
Christine Hsu	Family Planning Consultant, Chinatown Service Center
Dr. Myoung Hee Min	Family Planning Consultant, Koryo Health Foundation
Sachiko Reece, RN	Mental Health Consultant, Asian Pacific Counseling Center
Milda Rimonte	Executive Director, Oriental Service Center

12:00 SECOND BICULTURAL PANEL:

Manote Kongthong	Thai Social Worker, Oriental Service Center
Ngoc Pham	Vietnamese Community Counselor, Asian Community Service Center
Bibi Sayakhot	Lao Job Developer, Pacific Asian Consortium in Employment
Carolyn Yano	Counselor Developmental Disabilities, Asian Rehabilitation Services

QUESTION AND ANSWER PERIOD

48



T.H.E. CLINIC FOR WOMEN, INC.
3860 West Santa Barbara Avenue • Los Angeles, Ca. 90008 • (213) 295-6571

Tuesday, October 31, 1978
L.A. Regional Family Planning Council
630 South Shatto Place

Asian Women's Health Project sponsored a seminar on Asian/Pacific Women in October, 1978. The seminar was held at the LARFPC facility and was geared toward the LARFPC clinic staff. (See Exhibit 2.) Only two or three non-Asian, non-minority members of the LARFPC staff attended, thus demonstrating at another level, the need for LARFPC to fully comprehend the cause of Asian/Pacific under-utilization of family planning services.

2. Summary of Findings

(see next page for text)

C. Consumer Survey

The third task of the Asian Women's Health Project was to conduct a Consumer Survey (see Appendix E). The survey was distributed and/or administered by the project staff, key persons in the community, teachers of English as a second language, church groups, and community agencies and organizations.

The survey had four objectives:

- To compare prior conclusions with the opinions and attitudes of the population to be served.

  The prior conclusions regarding health and family planning needs of Asian/Pacific Women had been drawn from demographic and statistical data, interviews with Asian/Pacific key informants, and hospital and clinic surveys.

- To gather personal health data from a small, but in-depth, sample of women from various Asian/Pacific communities and economic backgrounds, religious and political beliefs, and geographic areas.

- To gather further information from these women regarding the type of health services being sought, the facilities currently being used (if any), and the problems faced in seeking health care.

- To determine the health education needs of the community.

  The overall intent of the survey was to test tentative conclusions about the family planning and health care needs of Asian/Pacific women with the women themselves. This procedure would ensure that any recommendations and proposals the Asian/Pacific Study Grant might make would be in keeping with the concrete needs of the Asian/Pacific community.

The Consumer Survey was translated into several languages:
Chinese, Japanese, Korean, Lao, Thai, and Vietnamese (see Appendix E.).

SUMMARY OF LARFPC AGENCY SURVEY: BARRIERS TO

Barriers To Family Planning	California Medical Center	Cedars-Sinai Medical Center	Chinatown Services Center	L.A. County Harbor/UCLA Medical Center	Hollywood-Wilshire District	John Wesley Hospital	Koryo Health Foundation	Mar Vista Planned Parenthood	Planned Parenthood World Population	Southwest Health District	T.H.E. Clinic For Women, Inc.
Language	X	X	X	X	X	X	X	X	X	X	X
Inaccessibility:											
Transportation problems	X	X	X			X	X				X
Lack of bilingual staff	X	X	X	X	X	X			X	X	X
Lack of bilingual signs	X	X	X	X	X	X			X	X	X
Cultural differences	X	X	X	X	X	X	X		X	X	X
Cost of services							X				
Lack of knowledge regarding family planning	X	X	X	X	X	X	X		X	X	

Code:

X = Presence of a barrier

1. Demographics of Consumer Survey Respondents

Three hundred surveys were distributed and 197 were returned. The survey respondents ranged from 15 to 73 years of age. Eighty percent of the women were within the prime childbearing years, the 20-39 year age bracket.

Eighty-four percent of the non-English-speaking women (non-ESW) were married, in contrast to the 58 percent of single English speaking women (ESW). Less than 10 percent of all the women were, or admitted to being, divorced or separated. (For many ethnic cultures, it is difficult to discuss and, many times, admit to divorce).

A significant number (34 percent) of the non-ESW were "housewives," probably because of an inability to get employment, caused by language difficulties and lack of childcare. For example, 15 percent of the non-ESW were unemployed: 39% of these women were able to find employment; many were in the United States as students on student visas. Most of these women were employed in factory jobs (e.g., as assemblers, seamstresses) or in service jobs (e.g., as waitresses, clerical personnel, community workers). Most of the ESW were also in service industry jobs such as those of office workers, secretaries, receptionists, and operators, as well as teachers, counselors, and other social service workers.

Twenty-two percent of the women had either graduated from college or had some college experience; 39 percent were high school graduates; and 5 percent had only a grammar school education.

Fewer non-ESW had either college or high school educations (31 percent and 33 percent, respectively). They had a larger proportion with only a grammar school education (14 percent). It is important to note that both ESW and non-ESW with a higher level of education showed more willingness to fill out the survey. Thus, the health problems and needs of Asian/Pacific women are even much higher than this survey suggests.

The religion most frequently mentioned was Christian (19 percent of all respondents, but primarily ESW). Buddhism followed, specified by 13 percent of all the women, and 34 percent of all the non-ESW. All of the Lao women were Buddhist. 12 percent of all the women were Catholic. However, most respondents did not belong to any faith.

Sixty-nine percent of the non-ESW had resided in the United States from 5 months to 3 years.

2. Personal Health Data

The number of non-ESW who did not receive regular checkups (routine gynecological exams) was more than twice as great as the number of those who did. The same ratio was true for women who did not receive breast examinations. The number of women who received pap smears was slightly lower than the number of those who never did , although some had not had a pap smear taken in 2 to 5 years!

The ESW had more access to these services, but a shocking 41.6 percent still were not receiving regular checkups. Twenty-six percent had never received a pap smear, and among those who had some had not received a pap smear since 1973. More women (77 percent) had received breast examinations, but again some had not had an examination since 1973, and most were not examined on a regular basis.

Thirty-six percent of the non-ESW had never used any method to postpone a birth--a figure very close to the 31 percent of the ESW. Condoms and birth control pills were the most widely used methods among the majority of users (44 percent and 41.6 percent, respectively). For many women, these were the only two methods known to them. Diaphragms (25 percent) and withdrawal (25 percent) were next in percentage of use among the ESW, closely followed by rhythm (23 percent), foam (23 percent), and IUD's (21 percent). Interestingly, none of the non-ESW had any experience with diaphragms, and only one had used foam. This finding could mean that condoms were being used alone without any backup method.

Three times as many non-ESW as ESW were unfamiliar with any birth control methods other than the ones they used, or had used previously. Among the ESW, the percentages were equal between those women who were familiar with other methods, and those who were not.

Over half of all the women said they turned to a doctor or other health worker when they needed medical help. This was contrary to all other indications from statistics, Key Informant interviews, and case histories. The women may have interpreted the question as a hypothetical one, since the survey and report as a whole clearly shows that they have been unable to receive adequate, health care, if any, because of language difficulties and other problems. Another explanation for this response may be that if they interpret "medical help" as "medical of life-and-death crisis," then they might turn to any doctor. Also, many of the Korean respondents seemed to be patients at Koryo Health Foundation (a Korean health facility). 50 percent of the women stated that there were no people who spoke their language at health facilities.

The ESW had slightly more access to health care, although over 25% of those who responded to the survey stated that when they sought health services, they could not find people who spoke their primary language. Most of these women also went to doctors, health workers, hospitals, and clinics when they had health problems.

Twenty-three precent of all the women sought out friends for medical help. Twenty percent of the ESW went to their parents, whereas only two non-ESW women saw this as an alternative. Priests/ministers and social workers were not greatly utilized.

Only 12 percent of the women mentioned other specific health problems or questions. More than a third of the women (37.5 percent) did not respond to this question. Headaches, extreme fatigue, and information on cancer were mentioned

several times. There was also concern about birth control pills and their side effects, as well as frustration centering on a lack of mobility to "find the right method for me." Additional concerns included abdominal and other body pains, nutrition, mental health, allergies, and the way in which emotions affect physical health.

Seventy percent of the non-ESW stated they had difficulty in seeking good health care. The main problem faced by 53 percent was an inability to communicate with their doctors' or health care workers because of language differences. About one quarter of the women indicated that they had financial problems and an inability to meet health care costs. A smaller percent stated that they had transportation problems or were not aware of any facilities they could turn to.

Twenty-five precent of the ESW women who responded to this question stated that they had difficulties in receiving good health care. Most of the women faced financial problems; some faced language and transportation problems, or didn't know of facilities. A number of women responded with complaints regarding the lack of many good doctors and the insensitivity they often encountered.

The last multiple-choice question (number 7) was posed to get an initial assessment by the respondents regarding the qualities they would prefer in their health worker. Sixty-one percent of all who responded wanted a health worker who spoke in their native tongue; the overwhelming majority of non-ESW (77 percent) wanted bilingual doctors. Over half of the women in both groups preferred a woman health worker. This seems to be a low estimate, given past contacts and discussion with Asian/Pacific women. Stereotypes of health workers and doctors as being male may still have a strong hold on the community. Most of the non-ESW had a stated preference for Asian/Pacific health workers. In comparison, the ESW rated this as a lightly lower priority.

3. Main Problems

Almost one half of all the women felt that language was a major problem for the Asian/Pacific community. Health-related issues were another main problem identified by a significant number of both groups of women, as were the need for jobs and vocational skills, and other problems related to under-employment. Immigration was another important area of concern. Other issues mentioned were common to many low-income minority communities: childcare, education, transportation, housing, senior citizens. Concerns were also expressed in connection with questions of assimilation and culture, and the lack of a cohesive, united community.

A large number of health education need areas were identified. High on the list were preventive health care, areas relating to women's health (family planning, menopause, prenatal care, vaginal infections, etc.), health consumer issues, diet-exercise-nutrition, and basic health education.

4. Summary of Findings

To summarize, the Consumer Survey validated conclusions from previous surveys, interviews, and data research of the Asian Women's Health Project. The responses from the community women themselves supported the need for bilingual/bicultural healthworkers, and the need and desire on the part of the community for health education available in the Asian/Pacific languages. The survey also verified the underutilization of family planning services; even those women who claimed they received regular checkups recorded their last pap smear or breast examination as far back as 1973! One wonders what type of health examination these women received, and with what regularity.

D. Statistical Search and Literature Review

During the search for demographic and health-related information, a number of limitations were encountered. The most significant was the lack of data accounted for by a number of reasons. Until recently, Asians were categorized as "Other." Many times all Asian/Pacifics were lost in the "Other " category. Or the data for the Asian/Pacific people were considered so small compared with those for the white, black, and Spanish-surnamed populations that the numbers were deemed "statistically insignificant." In these cases, the percentages were recorded as 0 percent or were deleted, with a resulting further lack of information.

There were no accurate, up-to-date statistics on Asian/Pacific immigrants since the 1970 census. In addition, the increase in intermarriage, and mistaken names such as Ohara (a Japanese surname) for O'Hara (an Irish surname), added to Asian/Pacific under-representation.

There were many inconsistencies in data, among them the fact that categorical titles for Asian/Pacifics were inconsistent. For example, in several consecutive years, "Other" went from "Oriental" to "Asian" to "Japanese, Chinese, Korean, Pilpino." Pilipinos were sometimes grouped with people of Spanish surname, and sometimes, with "Asians." Sometimes they were placed in the "Other' category.

The effects of institutional insensitivity (racism) illustrated above were further compounded by the fears and experiences of many recent immigrants. Frightened by the possibility of deportation, newly immigrated Asian/Pacifics tended not to seek health care or report pertinent health information that might jeopardize their immigration status. Also, census taking and other surveys were not conducted in Asian languages, and health facilities did not offer access to those not speaking English.

In spite of these limitations, the following information was obtained.

Statistical Search

The Statistical Search drew from the following sources:

- An August 1977 publication by the Los Angeles County Commission on Human relations entitled Asian/Pacific People in the Los Angeles County Labor Force.

- Annual Reports of the U.S. Immigration and Naturalization Services from 1970 to 1976.
- Statistics compiled by LARFPC.
- Information compiled by the Los Angeles County Department of Health Services.
- Information from the Los Angeles County/USC Cancer Surveillance Program.
- Statistical information from the Los Angeles County/USC Women's Hospital porta-pap clinic.

Asian/Pacific Population Growth

The Statistical Search revealed a tremendous growth of the Asian/Pacific population both in the U.S., and in California and Los Angeles.

According to the 1970 U.S. Census, Asian/Pacific peoples in the United States included 591,300 Japanese of whom 36 percent (N = 213,277) were living in California. (See Exhibits 4 and 5). Of those in California, 49 percent (N = 104,994) were residing in Los Angeles County. 26 percent (N = 27,151) were of childbearing age (15 to 44 years). There were 435,100 Chinese in the U.S., of whom 39 percent (N = 170,419) were living in California. Of those in California 24 percent (N = 41,500) were residing in Los Angeles County. 26 percent (N = 10,674) were females of childbearing age. There were 343,100 Pilipinos in the United States, of whom 40 percent (N = 138,859) were living in California. Of those in California, 24 percent (N = 32,018) were residing in Los Angeles County. 28 percent (N = 8,856) were females of childbearing age. There were 65,510 Koreans in the United States of whom 24 percent (N = 16,684) were living in California. Of those in California, 23 percent (N = 9,395) were residing in Los Angeles County. The number of females of childbearing age was not available.

More recent estimates of the number of Asian/Pacific people in Los Angeles County were given in an August 1977 publication of the Los Angeles County Commission on Human Relations, Asian/Pacific People in the Los Angeles County Labor Force. In 1977, according to that publication the population of Los Angeles County included 160,000 Japanese (an increase of 55,922 persons from 1970); 90,000 Chinese (an increase of 49,202 persons from 1970); 90,000 Pilipinos (an increase of 56,541 persons from 1970); 85,000 Koreans (an increase of 76,350 persons from 1970); 30,000 Vietnamese; 5,000 Cambodians; 41,000 Samoans; 10,000 Guamanians; 2,000 Sri Lankans; and 6,000 Laotians. Information was not available for Thais or Southeast Asians. (See Exhibit 6.) The total Asian/Pacific population for Los Angeles County in 1977 amounted to 7.38 percent (N = 519,000) of the total population of the County. This figure represented a 4 percent increase over the 1970 Los Angeles County.

EXHIBIT 4

ASIAN/PACIFIC PEOPLES IN THE UNITED STATES AND IN CALIFORNIA, 1970

	Total	Males	Females	Females, 15-44 Yrs. of Age	Total	Males	Females	Females-15-44 Yrs. of age
Japanese	591,300	271,998	319,302	160,526	213,777	100,204	113,073	58,703
Chinese	435,100	230,603	204,497	104,233	170,419	88,286	82,133	42,257
Pilipino	343,100	188,705	154,395	83,807	138,859	77,843	61,016	32,463
Korean	65,510	INA	INA	INA	16,684	7,050	9,634	INA

Note: INA = Information not available.

Sources: A Study of Selected Socio-Economic Characteristics of Ethnic Minorities, based on the 1970 Census Vol. II: Asian Americans
Japanese, Chinese, and Filipinos in the U.S. Subject Reports. U.S. Dept. of Commerce. Social & Economic Statistics Administration. Bureau of the Census 1970. PC (2) - 1G.

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EXHIBIT 5

ASIAN/PACIFIC PEOPLE IN LOS ANGELES COUNTY, 1970

	Total Number	Males	Females	Females 15-44 Yrs. of Age
Japanese	104,994	50,856	54,138	27,151
Chinese	41,500	21,840	19,660	10,674
Pilipino	32,018	16,779	15,239	8,856
Korean	9,935	INA	INA	INA

Note: INA = Information not available

Sources: A Study of Selected Socio-Economic Characteristics of Ethnic Minorities, based on the 1970 Census Vol. II: Asian Americans Japanese, Chinese, and Filipinos in the U.S., Subject Reports. U.S. Department of Commerce. Social and Economic Statistics Administration. Bureau of the Census 1970. PC (2)-1G.

EXHIBIT 6

COMMUNITY ESTIMATES OF ASIAN/PACIFIC PEOPLES IN LOS ANGELES COUNTY, 1975, 1976, AND 1977.

	Community[1] Estimates (1975/1976)	Percentage	Asian[2] Community Svc. Ctr. Estimates (1976)	Percentage	Asian[2] Community Svc. Ctr. Estimates (1977)	Percentage
Total County Population	7,296,215	100.00	7,018,000[3]	100.00	7,040,000[3]	100.00
Categories						
Japanese	150,000	2.06	150,000	2.14	160,000	2.27
Chinese	80,000	1.10	90,000	1.28	90,000	1.28
Pilipino	85,000	1.16	80,000	1.14	90,000	1.28
Korean	80,000	1.10	80,000	1.14	85,000	1.21
Vietnamese	11,000	0.15	INA	-	30,000	0.43
Thai	15,000	0.21	15,000	0.21	INA	-
Cambodian	4,000	0.05	INA	-	5,000	0.07
Samoan	20,000	0.27	40,000	0.57	41,000	0.58
Guamanian	5,000	0.07	INA	-	10,000	0.14
Sri Lankan	INA	-	2,000	0.03	2,000	0.03
Southeast Asian	INA	-	35,000	0.50	INA	-
Laotian	INA	-	INA	-	6,000	0.09
SUM OF ABOVE	450,000	6.17	492,000	7.01	519,000	7.38

Sources:

(1) Human Resources Commission Community Estimates for Racial/Ethnic Populations of Los Angeles County - 1975 (individual sources available upon request).

(2) Asian Community Service Center Estimates for 1976 and 1977 for various categories.

(3) Los Angeles County Department of Regional Planning Estimates, July 1976 (provisional) and January 1977 (tentative).

These figures confirmed the rapid growth of the Asian/Pacific community in Los Angeles County. The Korean, Chinese and Pilipino communities have experienced the fastest growth--883 percent, 121 percent, and 169 percent, respectively. The sudden influx of Indochinese refugees also has boosted the Asian/Pacific population.

The Asian/Pacific community ranges over the entire County of Los Angeles; however, the majority of the people reside in the City of Los Angeles. According to a 1977 City survey, the Asian/Pacific community composed 17.89 percent of the population in Los Angeles Councilmanic District Number 4. This figure represented a growth of 106 percent over that for 1970. Other City Council districts in which Asian/Pacifics represent more than 10 percent of the residents were Councilmanic Districts Number 10 and Number 6 (see Exhibit 7).

Much of the recent growth is the result of relatively high immigration rates within the last 8 years. Throughout most of this century, immigration quotas levied against persons from other than European or Western Hemisphere nationalities limited Asians entering this country to a very small number. Since the end of World War II, however, a number of immigration laws have been revised to gradually increase the number of Asians allowed to enter this country, and the Asian population has grown markedly. Most recently, the 1965 repeal of national quotas has helped to increase Asian immigration.

In 1965, before the newest legislation went into effect, only 5 percent of all immigrants to this country came from Asia. By 1970, the proportion was up to 20 percent and, by 1973, to nearly one quarter (24 percent) of the total. During the 5year period between 1965 repeal of national quotas has helped to increase Asian immigration.

According to U.S. Immigration and Naturalization Service Annual Reports from 1970 to 1976, 301,044 Asian/Pacific women immigrated to the United States from Asian/Pacific countries during those years. (See Exhibit 8). Of these women 62.2 percent (N = 187,333) were between the ages of 20 and 29 years; 28.2 percent (84,400) were between the ages of 30 and 39 years; and 9.7 percent (29,311) were between the ages of 40 and 49 years. The ages of 15 to 44 years are considered the childbearing ages. However the U.S. Immigration and Naturalization Service data are available only in 10-year increments. From 1970 to 1976, there was a 43.7 percent increase in the total number of Asian/Pacific women between the ages of 20 and 49 years who immigrated to the United States. Although detailed data did not indicate the percentage of women who have settled in the Los Angeles County area, increased figures in the number of Asian/Pacific Islanders in Los Angeles could indicate that a significant number have moved to this area. The information also indicates that younger Asian/Pacific women are immigrating to the United States. These are women who face a high risk of pregnancy, and who would probably require family planning or family planning related services.

EXHIBIT 7

COUNCIL DISTRICTS
CITY OF LOS ANGELES
1975

EXHIBIT 8

IMMIGRANT ASIAN/PACIFIC WOMEN ADMITTED TO THE UNITED STATES, 1970-1976.

Year	AGE 20-19 Yrs.	30-39 Yrs.	40-49 Yrs.	Total
1970	20,337	10,168	3,492	33,997
1971	24,424	11,675	3,336	39,435
1972	28,258	12,995	3,836	45,089
1973	28,598	12,237	4,139	44,974
1974	28,227	12,361	4,492	45,080
1975	27,024	11,886	4,703	43,613
1976	30,465	13,078	5,313	48,856
1970-1976 TOTAL	187,333	84,400	29,311	301,044
Percentage	62.2	28.0	9.7	100

Source: U.S. Immigration and Naturalization Services Annual Reports from 1970 to 1976.

At the time of the 1970 Census, population figures indicated that well over one-third of Asian/Pacific persons living in the United States were in California. Thirty-six percent of all Chinese, 40 percent of all Filipinos, and 36 percent of all Japanese lived in the state. Most of these persons were clustered in the urban areas--primarily Los Angeles and San Francisco.

To determine health needs of Asian/Pacific women, it is also necessary to examine age-sex distributions within the population. In the beginning of the century, the Asians who came to this country to work and live were chiefly male laborers. Although some (primarily Japanese laborers) were able to bring their wives as well, males in all the Asian populations outnumbered females in every Census count until 1960. In that Census, Japanese women outnumbered Japanese men for the first time, the numbers of women having been greatly increased by the thousands of Japanese women who had married Americans during the United States occupation of Japan. In other ethnic groups, the trend has also swung toward a predominance of women immigrants, with the result that Asian female populations in this country are growing at a faster rate than the Asian male populations.

The increase in Asian/Pacific women immigrating to this country is occurring primarily among young women. Many factors may contribute to this predominance of young women in the immigrant population. During the U.S. conflict in Vietnam, the United States had servicemen and civilians throughout Asia and, inevitably, large numbers of marriages took place between Asian women and American men.

Asian men who had become U.S. citizens were finally able to marry and bring to this country Asian wives (in many cases women who were one or two generations younger than themselves). Between 1965 and 1973, 87,000 women from Asia immigrated to the United States as wives of Asian and non-Asian U.S. citizens (data from U.S. Immigration and Naturalization Service Annual Reports, 1965-1973).

Single women also have immigrated to this country. As cities in Asia have become overcrowded, women have immigrated to the United States seeking opportunities for a better life. Mandatory military service requirements in such countries as Korea and Formosa, on the other hand have limited male immigration.

In reviewing data on Japanese, Chinese, and Pilipino women in the city of Los Angeles (SMSA) the 1970 Census indicated the following totals and percentages, shown in tabular form:

Asian/Pacific Women in the City of Los Angeles:
Population Figures

Ethnic Group	Women		Women 15 to 44 Years of Age		
	Total No.	Percent of Ethnic Group	Total No.	Percent of Total No. of Women	Percent of Total No. in Ethnic Group
Japanese	28,213	51	14,070	50	25.0
Chinese	19,660	47	10,674	54	25.0
Filipino	8,697	47	5,305	61	28.5

Source: U.S. Census, 1970, by Standard Metropolitan Statistical Area (SMSA).

On the basis of 1970 Census figures for these three ethnic groups, plus immigration data on women, it is estimated conservatively that from 25 to 30 percent of the total population are women of childbearing age, 15 to 44 years. If estimates use the figure of 519,000 Asian/Pacific persons residing in Los Angeles County in 1977, approximately 129,750 (25 percent) could be women of childbearing age. This figure would represent a conservative estimate, given the larger percentage of young Asian women immigrants during the last 8 years.

Information gathered from the U.S. Census Bureau revealed a relatively low percentage of female heads of families for Japanese, Pilipino, and Chinese: 9.3 percent (N = 2,361): 8.6 percent (N = 642); and 6.9 percent (N = 638) respectively. (See Exhibit 9.) Compared with the national average, the percentage of Asian working women showed that more than one-half of the Japanese, Pilipino, and Chinese women over 16 years of age were working: 53.3 percent (N = 40,666); 63.1 percent (N = 10,540); and 51.4 percent (N = 13,941), respectively.

The U.S. Census Bureau indicated a substantial low-income grouping among Asians. Over one-third of all Japanese, Pilipinos, and Chinese women were found to be earning $3,000 per year or less. The median annual income was $3,582 for Japanese women; $4,152 for pilipino women; and $2,883 for Chinese women. Further analysis showed these income levels to be lower than those of other groups. The impact of the recent influx of Indochinese refugees, many with language problems and without salable skills, has not yet been documented.

It has been documented, DHEW, (Asian American Field Study, May 1977) that the use of public social services by poorer Asian/Pacific individuals falls far short of use by other groups. The situation applies to health, education, and welfare services. The study, conducted in Los Angeles, San Francisco, low utilization rates among eligible low-income Asians had resulted from lack of information, fears of using government programs, and, in particular, barriers to service including language and cultural difficulties. Upwards of 70 percent of eligible Japanese, Pilipinos, Samoans, Koreans, and Chinese were not receiving assistance.

EXHIBIT 9

ASIAN/PACIFIC WOMEN IN THE COUNTY OF LOS ANGELES:
Socioeconomic Data, 1970

	Japanese	Pilipino	Chinese
Total Number of Women in Los Angeles County	54,138	15,239	19,660
Percentage Rates of Women to Men	51.5	45.5	48.1
Total Number of Women, 15-44 years	27,151	8,856	10,674
Total Number of Families	25,372	7,446	9,141
Total Number of Families Headed by Women	2,361	642	638
Percentage of Total Number of Families	9.3	8.6	6.9
Women 16 Years of Age and Older in the Labor Force	40,666	10,540	13,941
Percentage of Total Number of Women Working	53.3	63.1	51.4
Women with Incomes of $3,999 or Less	15,400	3,672	5,817
Percentage	37.8	34.8	41.7
Los Angeles County Data for Individuals Below the Poverty Level			
Total Number of Families Headed by Women Percentage of Total	392	206	78
Families Below Poverty Level	30.5	28.3	9.7
Mean Size of Family	3.32	3.80	4.19
Mean Income Deficit	$1,672	$1,773	$1,805
Median Income of Women	$3,582	$4,152	$2,883
Mean Income of Women	$4,127	$4,366	$3,659

Source: U.S. Census Bureau; Subject Reports PC(2)-1G

EXHIBIT 10

LARFPC CLINIC PATIENT TOTALS
PLANNED PARENTHOOD WORLD POPULATION, 1977

	Chinese Number	Percent	Japanese Number	Percent	Filipino Number	Percent	Korean Number	Percent	Total Asian/Pacific Number	Percent	Patient Total All Races
Baldwin Park	3	0	1	0	1	0	2	0	7	0	1,222
Canoga Park	12	0	16	0	11	0	1	0	40	0	4,994
El Monte	0	0	1	0	2	0	3	0	6	0	1,953
Mar Vista	22	1	30	1	12	1	3	0	67	3	2,341
Pomona	10	0	15	0	11	0	3	0	39	0	3,335
Sherman Oaks	3	0	3	0	1	0	0	0	7	0	686
South Bay	0	0	10	4	3	1	0	0	13	5	281
Eighth St. Hq.	76	2	81	2	5	0	5	0	167	4	4,722
Total	126	1	157	1	46	0	17	0	346	1	19,539

NOTE: (1) Percent of patient total, all races.

Source: LARFPC Statistics—total numbers of Asian/Pacific women patients served at PPWP Clinics, 1977.

EXHIBIT 11

LARFPC CLINIC PATIENT TOTALS

	Chinese Number	Percent	Japanese Number	Percent	Pilipino Number	Percent	Korean Number	Percent	Asian/Pacific Number	Percent	Patient Total All Races
Clinica Libra	1	0	1	0	9	1	1	0	12	0	704
East Valley	7	0	14	0	6	0	6	0	33	0	3,499
Foothill	13	1	8	1	5	0	1	0	27	2	1, 403
Harbor	5	0	11	1	13	1	3	0	32	2	1,313
Hollywood-Sunset	4	0	8	1	12	1	5	1	29	3	901
HOY	1	0	3	0	1	0	0	0	5	0	690
Los Angeles	9	1	12	1	6	1	3	0	30	3	998
North East	2	0	3	0	3	0	0	0	8	0	735
South Bay	7	0	43	0	14	0	4	0	68	1	3,760
Southern California Council of Free Clinics	0	0	0	0	0	0	0	0	0	0	0
TOTAL	49	0	103	1	69	0	23	0	244	1	14,003

Note: (1) Percent of patient total, all races.

Source: LARFPC Statistics—total numbers of Asian/Pacific women patients served at Free Clinics, 1977.

b. Los Angeles Regional Family Planning Council (LARFPC) Clinics

Although the population data indicated a growing number of Asian/Pacific women in Los Angeles County, utilization rates cited do not reflect an increase in services received by Asian/Pacific women. Investigation into the Asian/Pacific patient loads of the LARFPC clinics in Los Angeles County substantiated the finding of under-utilization of family planning clinics by this population. The statistics on patient load were obtained from LARFPC-funded clinics in three categories: Planned Parenthood World Population Clinics, free clinics, and clinics belonging to the Los Angeles County Department of Health Services.

The Planned Parenthood facilities include eight clinics, which served a total of 346 Asian/Pacific women between January and December 1977 (see Exhibit 10). The Eighth Street clinic (in the heart of a large Asian community) served the largest number — 167 (four percent of their total patient load).

In 1977, the Free Clinic system, which includes 10 clinic sites, served a total of 244 Asian/Pacific women (one percent of their total patient load). (See Exhibit 11.)

The Los Angeles County Department of Health Services ambulatory family planning clinic system serves five health regions. The Central Health Region includes clinics located in the largest concentration of Asians. (See Exhibit 12.) These clinics served only 59 Asian/Pacific women during 1977. The 11 clinics in the San Fernando-Antelope Valley Health Region served 89 Asian/Pacific women. The Coastal Health Region includes 13 clinics that served 76 Asian/Pacific women. The San Gabriel Valley Health Region includes eight clinics at which 83 Asian/Pacific women were served. The Southeast Health Region, with 8 clinic sites, served 5 Asian/Pacific women. In sum, Los Angeles County's 47 clinics served the extremely small total of 312 Asian/Pacific women in the period from January to December 1977. The figure represents less than 1 percent of the total number of patients served by the County.

EXHIBIT 12
LARFPC CLINIC PATIENT TOTALS
LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES, 1977

	Chinese Number	Percent	Japanese Number	Percent	Pilipino Number	Percent	Korean Number	Percent	Asian/Pacific Number	Percent	Patient Total All Races
Central Region: District Site											
Central	12	1	2	0	6	0	2	0	22	1	1,241
East Los Angeles	0	0	1	0	0	0	1	0	2	0	2,510
Hollywood-Wilshire	4	0	2	0	13	1	6	1	25	2	914
Marvilla	0	0	0	0	0	0	0	0	0	0	0
Northeast	1	0	1	0	0	0	0	0	2	0	1,823
Southwest	2	0	0	0	1	0	2	0	5	0	1,586
West Hollywood	1	0	0	0	1	0	1	0	3	0	217
Coastal Region: District Site											
Bellflower	0	0	0	0	0	0	1	0	1	0	584
Harbor	0	0	0	0	1	0	0	0	1	0	298
Hawthorne Gardens	0	0	1	0	0	0	0	0	1	0	488
Imperial Heights	0	0	0	0	2	0	1	0	3	0	847
Inglewood	0	0	4	0	3	0	1	0	8	0	737
Lakewood	0	0	0	0	0	0	0	0	0	0	0
Lawndale	1	0	4	1	5	1	9	1	19	3	694
Norwalk	1	0	0	0	1	0	1	0	3	0	538
Torrance	2	0	6	1	4	1	6	1	18	3	454
Venice	7	1	7	1	0	0	0	0	14	2	1,188
Villa Carson	0	0	0	0	0	0	0	0	0	0	0
Santa Monica	4	1	0	0	0	0	1	0	5	1	322
Wilmington	0	0	0	0	3	1	0	0	3	1	212

Note: (1) Percent of patient total, all races

Source: LARFPC Statistics — Total numbers of Asian/Pacific women patients served at Los Angeles County Clinics, 1977

EXHIBIT 12 (Continued)

	Chinese Number	Percent	Japanese Number	Percent	Pilipino Number	Percent	Korean Number	Percent	Asian/Pacific Number	Percent	Patient Total All Races
San Fernando/ Antelope Valley Region: District Site											
Burbank	0	0	0	0	6	1	0	0	6	1	506
Canoga Park	3	0	0	0	0	0	2	0	5	0	680
Glendale	7	1	0	0	7	1	5	0	19	2	1,068
Lancaster	4	1	3	0	1	0	1	0	9	1	740
North Hollywood	2	0	2	0	1	0	2	0	7	0	920
Olive View Hospital	7	0	6	0	10	0	5	0	28	0	2,370
Pacoima	0	0	2	0	1	0	0	0	3	0	1,772
San Fernando	0	0	0	0	0	0	0	0	0	0	131
Tujunga	0	0	0	0	0	0	0	0	0	0	421
Valencia	2	0	1	0	1	0	0	0	4	0	953
Van Nuys	4	0	1	0	3	0	0	0	8	0	2,242

Note: (1) Percent of patient total, all races

Source: LARFPC Statistics — Total numbers of Asian/Pacific women patients served at Los Angeles County Clinics, 1977

EXHIBIT 12 (Continued)

	Chinese Number	Percent	Japanese Number	Percent	Pilipino Number	Percent	Korean Number	Percent	Asian/Pacific Number	Percent	Patient Total All Races
San Gabriel Valley Region:											
Alhambra	33	1	10	0	4	0	1	0	48	1	2,230
Baldwin Park	0	0	1	0	2	0	0	0	3	0	618
El Monte	0	0	0	0	0	0	0	0	0	0	257
La Puente	4	0	2	0	4	0	3	0	13	0	1,403
Rosemead	0	0	2	0	1	0	0	0	3	0	468
Santa Fe Springs	1	0	4	0	2	0	0	0	7	0	949
Whittier	1	0	2	0	2	0	2	0	7	0	2,784
Pico Rivera	0	0	0	0	2	0	0	0	2	0	1,014
Southeast Region:											
Bell Gardens	0	0	0	0	0	0	0	0	0	0	779
Compton	2	0	0	0	1	0	1	0	4	0	930
Florence-Firestone	0	0	0	0	0	0	0	0	0	0	548
North Enterprise	0	0	0	0	0	0	0	0	0	0	707
Paramount	0	0	0	0	0	0	0	0	0	0	465
San Antonio	0	0	0	0	0	0	0	0	0	0	1,257
Slauson/Main (Hubert Humphrey)	0	0	0	0	0	0	0	0	0	0	1,456
South	0	0	0	0	0	0	1	0	1	0	779

Note: (1) Percent of patient total, all races

Source: LARFPC Statistics -- Total numbers of Asian/Pacific women patients served at Los Angeles County Clinics, 1977

EXHIBIT 12 (Continued)

SUMMARY OF LARFPC CLINIC PATIENT TOTALS

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES, 1977

PATIENTS

REGION	Chinese	Japanese	Pilipino	Korean	TOTAL Asian/Pacifics	PATIENT TOTALS ALL RACES
Central	20	6	21	12	59	8,291
Coastal	15	22	19	20	76	6,382
San Fernando/ Antelope Valley	29	15	30	15	89	10,617
San Gabriel Valley	39	21	17	6	83	9,723
Southeast	2	0	1	2	5	6,921
TOTAL	105	64	88	55	312	41,934

EXHIBIT 12 (Continued)

SUMMARY OF LARFPC CLINIC PATIENT TOTALS

THREE TYPES OF CLINICS, 1977

PATIENTS

TYPE OF CLINIC	Chinese Number	Percent	Japanese Number	Percent	Pilipino Number	Percent	Korean Number	Percent	Asian/Pacific Number	Percent	Patient TOTAL All Races Number	Percent
PPWP	126	1	157	1	46	0	17	0	346	1.8	19,539	
Free Clinics	49	0	103	1	69	0	23	0	244	1.0	14,003	
L.A. County	105	0	64	0	88	0	55	0	312	0.7	411,934	100

The primary purpose of the family planning program at LARFPC is to make contraceptive care available to as many women as possible. However, of the total of 133,870 patients who used the LARFPC clinics in the period from January to December 1977, only 4,080 were Chinese, Japanese, Pilipino, and Korean women. The breakdown is as follows:

Chinese women	1 percent	(N = 809)
Japanese women	1 percent	(N = 973)
Pilipino women	0 percent	(N = 612)
Korean women	1 percent	(N = 1,686)

One may surmise that the percentage of Asian women unserved by LARFPC are seeking out health care from private practitioners and private medical doctors. To judge from the Consumer Survey, however, the majority of women did not know where to seek health care, and did not receive regular health examinations. The conclusion would be that there is a severe service delivery gap in family planning for Asian/Pacific women.

On the basis of recent data regarding population estimates and utilization, it is estimated that at least 16,868 Asian/Pacific low-income women in Los Angeles County would be eligible for subsidized family planning services. However, a comparison of this figure with the total number of 4,080 Asian/Pacific women who received family planning services in 1977, indicates that 12,568 are in need. Clearly, in Los Angeles County alone, 75 percent of the Asian/Pacific women of childbearing age are not being served. A review of total statewide data also indicates significant underserved Asian/Pacific patient populations in San Francisco and other parts of the Bay area.

The LARFPC statistics of patient utilization prove beyond any doubt, the serious extent of Asian/Pacific under-utilization of family planning services. These and other data attest to the need for subsidized services for this population.

c. Profile of LARFPC Asian/Pacific patients

Several of the major hospitals which have family planning clinics do not serve large numbers of Asians, although the clinics are either in areas of high concentrations of Asians, or near an Asian/Pacific community. For example, California Hospital, a privately owned hospital, and John Wesley Hospital, a Los Angeles County hospital, are in proximity to Chinatown, Little Tokyo, and the Temple Area (where a number of Pilipinos reside). Many Koreans also live near these facilities, yet their respective Asian/Pacific family planning patient loads are extremely low. The family planning clinic at California Hospital served 74 Asian/Pacifics during 1977. The breakdown is as follows:

Chinese women	2 percent	(N = 43)
Japanese women	0 percent	(N = 7)
Pilipino women	1 percent	(N = 18)
Korean women	0 percent	(N = 6)

The family planning clinic at John Wesley Hospital served 75 Asian/Pacifics during 1977 with a breakdown as follows:

Chinese women	0 percent	(N = 22)
Japanese women	0 percent	(N = 10)
Pilipino women	0 percent	(N = 14)
Korean women	1 percent	(N = 29)

The family planning clinic at Los Angeles County Harbor/UCLA Medical Center is in the heart of a large Pilipino and Samoan community, and is also situated in proximity to a large Japanese community in the Gardena-Torrance area. The clinic experienced the same kind of under-utilization rates described above, serving only 166 Asian/Pacific women, during 1977. The breakdown is as follows:

Japanese women	1 percent	(N = 79)
Pilipino women	1 percent	(N = 87)
Samoan women	INA percent	(N = INA)

These figures reveal a severe degree of under-utilization of family planning clinics and services.

Patient statistics compiled by LARFPC were reviewed to learn how the women who are currently using the family planning services initially learned about them. Regarding Asian women, LARFPC patient statistics showed that over half of them learned about a family planning clinic through a family member of friend, with the remainder learning about the availability of services via television, radio, or phone referral. A very small percentage learned of the availability of family planning services from a health worker or doctor.

LARFPC also analyzed 1977 family planning data obtained from a sample of Asian/Pacific women. The analysis covered responses of 4,080 Asian/Pacific women, out of a total of 133,870 women who used LARFPC for family planning services. The data were obtained on the first visit made in 1977 by women who were seeking services at a LARFPC-funded clinic. This first visit could have been either an initial visit or a return visit for a 1976 patient. (See Appendix F.)

When asked if they had ever used a form of birth control, 80 percent (N = 3,465) said "yes", and 20 percent (N = 863) said "no". The following prior methods of birth control were reported:

Oral Contraceptive	38 percent	(N = 1,600)
No form of birth control used	21 percent	(N = 884)
Condom	18 percent	(N = 745)
IUD	11 percent	(N = 457)
Rhythm Method	5 percent	(N = 203)
Foam	4 percent	(N = 151)
Diaphragm	3 percent	(N = 117)

The prior form of birth control had been obtained in the following ways:

Clinic	67 percent	(N = 2,143)
Drugstore	15 percent	(N = 470)
Private doctor	10 percent	(N = 319)
"Other" source not stated	8 percent	(N = 255)

The primary birth control methods used were as follows:

Oral contraceptive pills	44.0 percent	(N = 1,907)
Condoms	18.9 percent	(N = 821)
IUD's	11.0 percent	(N = 484)
No birth control method used	10.1 percent	(N = 441)
Foam	9.8 percent	(N = 426)
Diaphragm	4.9 percent	(N = 216)
Rhythm method	0.4 percent	(N = 18)
Sterilization	0.1 percent	(N = 2)
Other method not mentioned	0.3 percent	(N = 13)
Ovulation method	0.0 percent	(N = 0)

Chinese, Pilipino and Korean women between the ages of 25 and 34 years sought family planning services most frequently. Japanese women, however, tended to seek family planning services at a younger age. The majority of Japanese women who sought services were between 19 and 24 years of age.

Of the total number of Asian/Pacific women, Korean women showed the highest utilization of LARFPC services. The number of Korean women seeking family planning services might have been greater because there is in Los Angeles a Korean-language family planning clinic, Koryo Health Foundation Thus, with the availability of bilingual staff, the patient load increases. There are more outreach efforts toward the Korean community because they have a clinic specifically geared to cultural sensitivity toward Korean women. The other three Asian/Pacific groups do not have specific Asian-language clinics, and thus do not have access to a bilingual/bicultural facility where they may receive such a personal service.

d. Venereal Disease Among Members of the Asian/Pacific Community

The study reviewed venereal disease rates for Asian/Pacific men and women between 15 and 44 years of age, as indicated by the Los Angeles County Department of Health Services, Reportable Diseases by Age, Sex and Race, for 1976. As with the major portion of the health-related information and data collected on Asian/Pacific populations, the numbers and percentages were too small to permit any accurate analysis. Because the numbers were small, the percentage of variance was great.

Congenital syphilis (6.6 percent) had the highest incidence among venereal diseases, while secondary syphilis (0.1 percent) had the lowest. Several reasons for such reported low incidence would be (1) lack of sufficient health education for Asian/Pacifics regarding VD, and resulting inability to recognize symptoms and seek needed health care and treatment; (2) Culturally induced shame and embarassment, which keep Asian/Pacifics from seeking treatment; (3) the insensitivity of non-Asian/Pacific health workers to these cultural needs[6]; (4) the fact that some Asian/Pacifics may be receiving treatment from private practitioners and the Los Angeles County Department of Health Services therefore would not have their data. (See Appendix G.)

e. Los Angeles County USC Cancer Surveillance Information

The Los Angeles County/University of Southern California Cancer Surveillance Program is a rapid reporting system which collects, from hospital pathology records, all reported incidences of cancer in Los Angeles County.[7]

In addition to data of pathologic diagnosis, organ site, and histologic type, information collected includes sex, age, birthplace, race and surname.[8]

The health analyst, Herman Menck ran a computer analysis of cancer cases in Asian women in Los Angeles County from 1972 to 1975. Reported cases included cancer of the breast, cervix, corpus, ovary, vulva, vagina, as well as other types of female cancer.

The incidence of breast cancer among Asian women in Los Angeles County was found to be 1.69 percent (N = 245); cases of cervical invasive cancer, 2.59 percent (N = 53); cancer of the corpus, 0.99 percent (N = 56); of ovarian cancer, 1.87 percent (N = 44); of cancer of the vulva, 1.26 percent (N = 6); vaginal cancer, 0 percent (N = 0); and of other types of female cancer in women, 4.13 percent (N = 409). In regard to the total number of cancer cases, Asian women in Los Angeles County had 1.62 percent (N = 409) of the cases of cancer in women out of a total of 25,144 cases reported for all the women in Los Angeles County. (See Exhibit 13.)

These numbers and percentages are low in comparison with the numbers and percentages of Asian women documented in the population. As was stated earlier, the Asian/Pacific population of Los Angeles County accounted for 7.38 percent of the total in 1977; and approximately half of the number were females. Therefore, approximately 3.69 percent of Los Angeles County residents were Asian/Pacific females as compared with the percentages seen in the total number of cancer cases reported for Asian women.

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[6] One woman reported being refused a VD test by a doctor because she was "a nice girl", and he was "sure she wouldn't have such a disease".

[7] Hisserich, J.S.; Martin, S.P.; and Henderson, B.E.: "An Areawide Cancer Reporting Network". Public Health Report 90, 1975, pp. 15-18.

[8] "Cancer Incidence in the Mexican-American". Mench, H.R.; Henderson, B.E.; Pike, M.C.; Mack, T.; Martin, S.P.; and Soo Hoo, J.: Journal of the National Cancer Institute, Vol. 55, No. 531, Sep. 1975.

EXHIBIT 13

CANCER IN ASIAN AMERICAN WOMEN IN LOS ANGELES COUNTY 1971-1975

	Breast	Cervix Invasive	Corpus	Ovary	Vulva	Vagina	Other female cancers	TOTAL Number
CENTRAL HEALTH SERVICES REGION DISTRICT								
Central	29	6	5	5	0	0	3	48
East Los Angeles	7	0	3	2	0	0	0	12
Hollywood/Wilshire	23	4	11	8	2	0	1	49
Northeast	17	4	7	1	0	0	0	29
Southwest	26	4	3	6	0	0	0	39
TOTAL	102	18	29	22	2	0	4	177
COASTAL HEALTH SERVICES REGION DISTRICT								
Bellflower	4	2	1	1	0	0	0	8
Harbor	4	1	0	1	1	0	0	7
Inglewood	24	6	8	1	0	0	0	39
Long Beach	12	4	1	0	0	0	0	17
Torrance	14	1	1	5	0	0	0	21
West	21	6	6	4	1	0	0	38
TOTAL	79	20	17	12	2	0	0	130
SAN FERNANDO/ ANTELOPE VALLEY HEALTH SERVICES REGION DISTRICT								
East Valley	1	1	0	3	0	0	0	5
Glendale	5	0	0	1	0	0	0	6
San Fernando	3	3	0	2	0	0	0	8
West Valley	3	1	1	0	1	0	1	7
TOTAL	12	5	1	6	1	0	1	26
SAN GABRIEL VALLEY HEALTH SERVICES REGION								
Alhambra	25	3	7	2	1	0	0	38
El Monte	3	3	0	0	0	0	0	6
Monrovia	3	1	0	0	0	0	0	4

NOTE: (1) These cancer cases were counted in two ways:

a. Incident cancer (patients already having cancer)
b. New cancer cases

EXHIBIT 13 (Continued)

	Breast	Cervix Invasive	Corpus	Ovary	Vulva	Vagina	Other female cancers	TOTAL Number
Pasadena	8	1	0	1	0	0	0	10
Pomona	3	0	1	0	0	0	0	4
Whittier	2	1	1	0	0	0	0	4
TOTAL	44	9	9	3	1	0	0	66
SOUTHEAST HEALTH SERVICES REGION DISTRICT								
Compton	3	1	0	1	0	0	0	5
San Antonio	5	0	0	0	0	0	0	5
South	0	0	0	0	0	0	0	0
Southeast	0	0	0	0	0	0	0	0
TOTAL	8	1	0	1	0	0	0	10
TOTAL Number of Cases, Asian American Women	245	53	56	44	6	0	5	409
TOTAL Number of Cases, Los Angeles County, All Women	14,430	2,039	5,603	2,350	473	128	121	25,144
Cases Among Asian American Women, as Percent of County Total, All Women	1.69	2.59	0.99	1.87	1.26	0	4.13	1.62

NOTE: (1) These cancer cases were counted in two ways:

a. Incident cancer (patients already having cancer)
b. New cancer cases.

Source: Cancer Surveillance Program, School of Medicine, Pathology Department.

One may infer that Asian/Pacific women are healthy and do not become sick. But there is an opposing view. The inference may be made that Asian women do not seek health care for female-oriented problems, for the reasons stated earlier in this report. Their cancers remain undetected, untreated, and unprevented, thus underscoring the severe under-utilization of health care facilities. Many times this under-utilization of women's health care leads to serious, permanent, and even fatal results.

f. Los Angeles County/USC Porta-Pap Clinic Information

The Porta-Pap Clinic is a mobile unit sponsored by the Los Angeles County/USC Women's Hospital, which provides free pap smears, pelvic and breast examinations and referrals. The clinic is funded in equal portions by the California State Department of Health and the Earl Carroll Cancer Clinic for Women. The porta-pap personnel also work in conjunction with the American Cancer Society, which provides health education and health-related written materials.

Between November 1973 and December 1977, 13 separate porta-pap clinics were sponsored by and for Asian women. (See Exhibit 14.) Services were given to 1,123 women -- and of those, 96.6 percent (N = 1,085) were Asian women. Of all the women, 0.2 percent (N = 3) were under 19 years of age; 9.9 percent (N = 112) were from 20 to 29 years of age; 28.8 percent (N = 324) were from 30 to 39 years of age; 33 percent (N = 371) were from 40 to 49 years of age; 18.3 percent (N = 206 were from 50 to 59 years of age; and 8.5 percent (N = 96) were 60 years and older

It was appalling to find that 61.8 percent (N = 307) of all the women served were between 30 and 49 years of age, and that 27.3 percent (N = 307) of all the women served were having their first pap smear! This is extremely surprising as the majority of women were over 29 years of age. Only 10.1 percent (N = 115) of all the women served were under 29 years of age.

Analysis of the incidence of disease in the women showed that the numbers and percentages were low: 0.4 percent (N = 5) were found to have had dysplasia; 0.08 percent (N = 1) were found to have had cancer in situ; and 0.08 percent (N = 1) were found to have had invasive cancer. The Abnormal pap smears also occurred in small numbers and percentages: 0.6 percent (N = 7) were found to be abnormal; 0.9 percent (N = 11) were found to be atypical; and 0.9 percent (N = 11) were found to be unsatisfactory. (See Exhibit 15.)

EXHIBIT 14

PORTA-PAP CLINIC STATISTICS: [1] AGE AND INCOME OF PATIENTS

LOCATION AND DATE OF CLINIC SESSION	AGE OF PATIENTS						INCOME OF PATIENTS
	19 Years and Under	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60 Years and Over	
Chinatown Service Center 11/29/73	0	14	41	52	21	6	INA
Asian Women's Center 5/4/74	1	15	15	14	8	6	INA
Oriental Service Center 11/2/74	1	13	13	14	22	9	INA
Chinatown Service Center 11/14/74	0	4	18	18	9	2	INA
Chinatown Service Center 11/21/74	0	3	17	25	15	7	INA
Chinatown Service Center 1/23/75	0	4	8	17	9	6	INA
Chinatown Service Center 4/10/76	0	12	28	62	36	11	INA
Koryo Health Foundation 9/25/76	0	16	40	26	17	2	12
Koryo Health Foundation 12/14/76	0	4	17	12	4	5	3
Oriental Health Foundation 5/10/77	1	8	30	20	16	8	8
Chinatown Service Center 8/27/77	0	10	19	43	28	30	26
Koryo Health Foundation 9/22/77	0	2	33	30	10	3	9
Korean Presbyterian Church 12/8/77	0	7	45	38	11	1	23
TOTALS	3	112	324	371	206	96	81

NOTE: [1] Women's Hospital of Los Angeles County/USC Medical Center has a portable pap smear clinic which services women throughout Los Angeles County. These 13 special clinic sessions were geared toward Asian women, and were held in Chinatown, The Asian's Women Center, Oriental Service Center, Koryo, Oriental Health Foundation facility and the Korean Presbyterian Church of Los Angeles Health Foundation facility.

EXHIBIT 15

PORTA-PAP CLINIC STATISTICS: [1] INCIDENCE OF DISEASE

Location and Date of Clinic Session	Number Of Patients		Number Of Patients Having First Pap Smear	Incidence Of Disease					
	Total Number Of Women	Total No. Of Asian Women		Dysplasia	Cancer in Situ	Invasive Cancer	Cytology Abnormal	Cytology Atypical	Cytology Unsatisfactory
Chinatown Service Center 11/29/73	144	129	48	0	0	0	0	1	0
Asian Women's Center 5/4/74	59	59	4	0	0	0	0	1	4
Oriental Service Center 11/2/74	72	67	10	0	0	0	0	0	1
Chinatown Service Center 11/14/74	51	50	0	0	0	0	0	0	0
Chinatown Service Center 11/21/74	67	67	18	0	0	0	0	0	3
Chinatown Service Center 1/23/75	44	41	15	0	0	0	0	0	2
Chinatown Service Center 4/10/76	149	142	40	1	0	0	1	4	1
Koryo Health Foundation 9/25/76	101	101	31	2	0	1	3	0	0
Koryo Health Foundation 12/14/76	42	40	16	0	0	0	0	0	0
Oriental Health Foundation 5/10/77	84	82	26	0	0	0	0	3	0
Chinatown Service Center 8/27/77	130	127	41	1	0	0	1	0	0
Koryo Health Foundation 9/22/77	78	78	21	1	0	0	1	0	0
Korean Presbyterian Church 12/8/77	102	102	37	0	1	0	1	2	0
TOTALS	1,123	1,085	307	5	1	1	7	11	11

NOTE: [1] Women's Hospital of Los Angeles County/USC Medical Center has a portable pap smear clinic which services women throughout Los Angeles County. These 13 special clinic sessions were geared toward Asian women, and were held in Chinatown, The Asian's Women Center, Oriental Service Center, Koryo, Oriental Health Foundation facility and the Korean Presbyterian Church of Los Angeles Health Foundation facility.

Several points may be made from this information. First, Asian women are not taking the initiative to seek women's health care on their own. This is evident, as the porta-pap clinic goes to the respective communities to provide services. Second, Asian women are not receiving health care until a later age than that at which most women begin to receive care. Third, it may well be that Asian women are, in fact, in search of good health care but that problems with transportation and difficulties with the English language plus a lack of knowledge of available health facilities, and the embarassment felt in seeking help regarding a female obstetrical-gynecological problem may prevent them from receiving care.

g. Illegitimate Live Births for Asian/Pacifics

The study reviewed illegitimate live births for the entire County of Los Angeles from 1974 to 1976. Japanese, Chinese and Pilipino populations showed a slight increase in the numbers of illegitimate live births as the age of women increased. No analysis from the data was possible, however, because of the small numbers of reported Asian/Pacific illegitimate live births. (See Appendix H.)

An important factor contributing to this low recorded incidence may be the cultural norms and value systems among Asian/Pacifics, which prevent illegitimate births from being reported or acknowledged.

Illegitimate live births for Asian/Pacific people were not enumerated before 1974; hence, no data were available for earlier years.

h. Illegitimacy Ratio

The Los Angeles County Department of Health Services publication of 1976 Vital Statistics has a special section on illegitimacy rates and ratios. Analysis was impossible because Asian/Pacific peoples were not enumerated but were subsumed in the "other" category.

i. Rates For Fetal Deaths and Live Births Among Asian/Pacifics

No significant trend could be ascertained from data regarding fetal deaths and live births among the Asian/Pacific community for the period from 1970 to 1976 for the enitre County of Los Angeles. (See Appendices I and J.) The totals among Pilipino, Japanese, and Chinese showed wide variances from year to year. In addition, no specific records broken down by Asian ethnicity were available until as late as 1974, and those rates cover only a small sample of Japanese, Chinese, and Pilipinos, once again pointing to a lack of data on Asian/Pacifics. No definite conclusions could be reached.

Fetal deaths and live births are an indication of maternal health status. The higher the health status of the mother, the lower the fetal death rate will be, and the higher the live birth rate will be.

2. Summary Of Findings

In summary, the Statistical Search indicated the following:

- The Asian/Pacific community in Los Angeles County has grown rapidly within the past 5 to 8 years and is continuing a rapid expansion. Such growth makes Asian/Pacifics a significant force in the area of health care (as well as in politics, human services, employment and other areas).

- There is severe under-utilization of health services by the Asian/Pacific community. In particular, very personal health services such as family planning and related health care (e.g., that related to illegitimate births) are extremely under-utilized and under-recorded.

- A major factor contributing to under-utilization is continuing institutional racism and insensitivity. Primary manifestations are the following:

  - The lack of importance placed on recordkeeping for the Asian/Pacific community, especially in regard to health. No accurate analysis can be made of data under the vague categorization of "other".

  - The lack of bilingual/bicultural employees, including statisticians and census takers; and the critical lack of health education and outreach.

  - Insensitivity toward Asian/Pacific patients.

- More efforts in health education and outreach are needed to overcome the cultural stigmas attached to family planning and related health care services.

3. Literature Review

This section is a compilation of information on family planning models and attitudes from various Asian and Pacific Island countries: Cambodia, Hong Kong, Indonesia, Japan, Korea, Laos, the People's Republic of China, Philippine Islands, Singapore, Taiwan, Thailand, and South Vietnam.

Understanding the conditions of life and attitudes toward health and family planning to which Asian/Pacific people are exposed in their respective countries, promotes insights into effective service and outreach methodologies that can be used in reaching Asian/Pacific communities throughout the United States. For this reason, it was important to understand the background of Asian/Pacific people and investigate their environment and situation regarding family planning prior to their immigration to the United States. For example, the Korean and Taiwanese women are approached in their respective countries on a door-to-door basis and rarely seek out family planning services on their own initiative. With no prior knowledge of these customs the American family planning clinic can itself experience a serious lack of communication between its Asian/Pacific clients and the agency. The family planning clinic may be waiting for the woman to come to its facility for services, while the woman may be waiting at home for the family planning outreach worker to come knocking at her door.

The purpose of this research therefore, was to review family planning practices in the native countries of Asian/Pacific peoples in order to understand more clearly certain attitudes toward family planning that exist among Asian/Pacific peoples in Los Angeles County today. A closely related aim was to gain insights on how to deal with these attitudes in the most positive way.

CAMBODIA

Reference:

Poulation Reference Bureau, Inc.: World Population Growth and Response 1965 - 1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 84:

The Cambodian government felt that the population was too small in comparison with the amount of the country's natural resources. Hence, there was an encouragement to increase the family size and the rate of population growth.

People are not concerned about limiting their family size because they are not restricted by the government and receive positive reinforcement for having large families.

Work in the rural villages and countryside demands a labor source that can be provided only by an increase in population. This is yet another incentive to increase the family size.

The International Family Planning Federation encountered difficulties because of the government's perspective about increased population and larger families. The clash between the Federation and the government may have severely limited or even eliminated family planning altogether.

Comments

These perspectives are probably carried over by immigrants coming into the United States. They have never been encouraged to limit their family size and feel it is good to have a large family — in fact, it is a cultural norm. Therefore, Cambodian women may not be aware of the availability of family planning services and may not be knowledgeable about spaced or planned births.

HONG KONG

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response1965-1975 A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 79:

In the British Crown Colony, Hong Kong, information on family planning and birth control is disseminated in several ways:

1. Clinics offer family planning services and hold special sessions to present family planning information to married couples and young people.
2. Welfare workers promote family planning at maternal/child health centers.
3. Radio, TV, and other media offer a means to attract public attention.
4. Family planning education is offered in the school curricula.
5. Posters stress the ideal two-child family
6. Low-cost oral contraceptives can be purchased at pharmacies without prescriptions.

The oral contraceptive is the most popular form of birth control.

Reference:

Chan, K.C.: "The Role of the Family Planning Association in Hong Kong's Fertility Decline." Studies in Family Planning, Vol. 7, No. 10, Oct. 1976.

Summary of Paragraphs, pp. 284-285:

In Hong Kong, two major types of outreach are used:

1. Media:

   Prior to 1966, posters, pamphlets and newspaper ads were the main source of publicity. At present, film showings, contests, and telephone inquiry services have been developed. Television and radio offer family planning messages.

2. Person-to-person Contact:

   a. Family planning workers need to continually motivate and recruit contraceptors. Although they desire to limit births, many women still require repeated motivation before accepting contraceptives.

   b. The most important referral source has been person-to-person contact between a prospective client and the family planning worker and between a prospective client and a satisfied client.

INDONESIA

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C. 1976.

Summary of Paragraphs, page 81:

Recent efforts have been made to bring family planning clinical services closer to the outlying regions, rural communities, and villages. The pill, condom, and IUD, in that order, are the most popular forms of contraceptives.

Traditional behavior is a serious obstacle to family planning efforts. First, the girls tend to marry very early. Statistics show that 22.5 percent marry under the age of 15 years. The median marrying age is 16.8 years. Second, a fairly large family of four to five children is considered desirable by almost everyone.

JAPAN

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 26:

In 1948, the Japanese government legalized abortion, and family planning services have become an accepted part of Japanese life. Abortion was made readily available and inexpensive.

Decreasing fertility rates in Japan since the 1930's may be due to several causes: (1) continued movement from rural areas, where fertility was relatively high, to cities; (2) raising of the age of brides at marriage; and (3) some extension of anti-natal practices within marriage.

Summary of Paragraphs, page 27:

After World War II, to restrict fertility in Japan was felt to be consistent with firmly rooted loyalties to the family, community, and the nation.

Summary of Paragraphs, page 31:

A number of hypotheses emerge from the studies that have been made on fertility trends in underdeveloped countries:

- The possible role of community leaders in movements toward restriction of fertility may be a critical factor.
- As the old sanctions for unlimited fertility break down under the impact of a new order, there may be a renewed emphasis on the values and responsibility of family life, working toward the planning of family size.
- The practice of birth control is powerfully influenced by the acceptability of available means and sources of information.

Summary of Paragraphs, page 83:

As mentioned in the "Underlying Differences of Fertility," Japan has the lowest birth rate and the highest gross national product (GNP) in Asia.

Summary of Paragraphs, page 84:

The Japanese national government has no specific family planning programs. However, it supports voluntary and local government efforts; promotes responsibile parenthood; and urges women to use contraception rather than abortion to control family size. The condom is the most popular form of birth control in Japan. Condoms are sold in vendings machines on the street, in drug stores, and in restrooms. Commerical outlets and door-to-door vendors are the main sources of supply.

Reference:

Koya, Yoshio, M.D.: "Why Induced Abortion in Japan Remains High." Research in Family Planning, Kiser, Clyde, ed. Princeton, New Jersey: Princeton University Press, 1962.

Summary of Paragraphs, pages 103-110:

If a woman cannot avoid pregnancy, she will resort to induced abortion for several reasons:

1. Desire to limit family size

2. The fact that new groups of people, particularly in rural areas and among lower classes, are starting to practice contraception.

3. Unsuccessful use of contraceptive

Koya assumes that the continued high incidence of induced abortion may be due either to the high failure rate in contraceptive practice, or to a strong motivation to limit family size.

Family planning in Japan was enhanced by two important changes that occurred. First, the "emancipation of sex" enabled people to talk about sex more openly and freely; and second, the "emancipation of women from the yoke of familism" gave them new freedom. The psychological trend (independence of the individual, pursuit of personal happiness) has apparently been one of the motivations in the prevalence of family planning.

Reference:

Noda, Minoru: "Contraception in Japan: Problems of Motivation and Communication." Research in Family Planning, Kiser, Clyde, ed. Princeton, New Jersey: Princeton University Press, 1962.

Summary of Paragraphs, pages 559-560:

Japanese parents limit their family size for several reasons:

1. Economic necessity
2. Rearing of the existing children
3. Protection of the mother's health
4. Enjoyment of life
5. Prevention of hereditary defects
6. Avoidance of dividing family property into small segments
7. Desire for increased opportunities for their children in a competitive society

Asian Women Health Project

PEOPLE'S REPUBLIC OF CHINA

Reference:

Fogarty, John E.: Barefoot Doctor's Manual. Washington, D.C.: Department of Health, Education, and Welfare, International Center for Advanced Study in the Health Sciences, 1974.

Summary of Paragraphs, page 173:

Several forms of family planning and birth control methods are used in the People's Republic of China. Herbs have been used for centuries by the Chinese for many different purposes, one of which is birth control and abortion.

Four specific herbal preparations were cited in the Barefoot Doctor's Manual:

1. A preparation from the tender sprouts of Pinus massoniana and the roots of white stipa, taken once after the conclusion of the menstrual period for 5 months in succession, is effective as a contraceptive for 3 years.

2. A preparation of coniogramme japonica, dysosma auranticocaulis, and paris polyphylla, taken during each day of the menstrual period, is an effective contraceptive for 8 months.

3. A preparation from flowers and roots of paris polyphylla, taken with wine at the end of the menstrual period, is an effective form of contraceptive for 1 year.

4. A preparation of dates from the palm trachycarpus excelsa, roots of bamboo phyllostachys nigra, white wine, and brown sugar, taken at the end of the menstrual period[1] once a day for 3 days in a row, is effective as a contraceptive for 1 year.

Summary of Paragraphs, page 174:

Condoms remain a popular device for birth control in China because they are "simple to use, with good results." In China, the rubber prophylactic is recycled after use. It is washed, cleaned, dried, and checked for leaks or breaks. Then it is dusted with talc and wrapped and stored for future use.

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[1]For exact amounts and preparations, see instructions in the Barefoot Doctor's Manual.

(Reference 22, Continued)

Summary of Paragraphs, pages 175-176:

Chinese herbal preparations are also used for sterilization. Four such herbal preparations are cited in the Barefoot Doctor's Manual.

1. Fresh roots from the date palm cooked with a hog's large intestine for a specific amount of time in specific quantities. Eating this preparation in one sitting after a menstrual period will render the woman sterile.

2. A preparation of upland sorghum (Kaoliang), hydrocotyle rotundifolia, and ophtopogon japonicus, taken within 2 weeks of the postpartum period.

3. A preparation of cuscuta japonica, carpesium divaricatum, and anemone vitifolia, auranticocaulis, taken once or twice after the menstrual period.

4. A preparation of alangium chinense, rhododendron molle, and undiluted sweet wine taken within 45 days of the postpartum period, or one day after the end of the menstrual period.[1]

Reference:

Snow, Edgar: "Population Care and Control." New Republic, May 1, 1971.

Summary of Paragraphs, page 21:

Four broad principles are now observed as laid down by the late Mao Tse-tung to be guidelines for medical and health workers:

1. Put prevention first (advocacy of birth control over abortion).

2. Serve the needs of workers, peasants, and soldiers wherever they may be.

3. Combine rural and urban public health measures with medical practice.

4. Unite Chinese traditional therapy (accupuncture and herbal remedies) with Western scientific knowledge.

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[1] For exact amounts and preparations, see instructions in the Barefoot Doctor's Manual.

(Reference 43, Continued)

Summary of Paragraphs, page 20:

There are several basic philosophies in the People's Republic of China which are related to birth control and family planning practices. The first states that "two children are the recommended limit". The second recommends an age of 25 years for the woman and 28 for the man, at the time of marriage.

Reference:

Orleans, Leo A.: "Family Planning in China." Abstracts from Medical Journals, 1960-1966, Studies in Family Planning, Vol. 4, No. 8, Aug. 1973.

Summary of Paragraphs, page 207:

In contrast to the philosophy mentioned by Snow, Orleans states in his article that women are encouraged to marry at 25 years of age, and men at 30. Obstetricians encourage the later marrying age. They also state that difficult first child births generally occur when the mother is between 15 and 22 years of age.

Summary of Paragraphs, page 208:

Health workers and doctors stress the advantages of later marriage considered from the standpoint of physiological maturity, emotional maturity, completed education, established occupation, economic stability, better living standards, and, therefore, a better future for the offspring.

Induced abortion is discouraged as harmful to the health of the mother. Choice of the method of birth control is recommended to be a joint decision between the husband and wife. Medical and health workers are exhorted to delay marriage and practice birth control, thus providing role models to encourage the masses.

Reference:

"Family Planning in China." Journal of American Medical Association, Vol. 215, Nos. 1-6, 1971.

Summary of Paragraphs, page 1044:

Mao Tse-tung advocated birth control over abortion; and when a father had had the desired number of children, he was encouraged to have a vasectomy. Mao also encouraged the people to adopt a goal of zero population growth.

Reference:

Tameyoshi, Katagiri: "A Report on Family Planning Programs in the People's Republic of China." Studies in Family Planning, Vol. 4, No. 8, Aug. 1973.

Summary of Paragraphs, page 216:

Pon Pu New Village is an example of a village that has been divided into residential areas. One person is responsible for family planning activities, including motivation and education of the area's residents.

Summary of Paragraphs, page 217:

The Nanking Textile Mill records information on the menstrual cycles of all its women employees and keeps the records on file at the factory where the women work. All the women receive an annual gynecological examination. Family planning education is based on the following:

1. Learning in a study group the relationship between family planning and communism, and learning about various birth control methods.

2. Offering criticism. People are motivated to criticize feudal ideas such as those that more children bring happinesss, and male children are desirable.

3. Remembering--reminding people of the suffering before the liberation, caused by too many people.

4. Listening to lectures motivating the following actions:

   a. to regulate family size to create a socialist country.

   b. to plan births and therefore possibly enhance the health of the child and the mother.

   c. to create time during which the mother can study and work.

   d. to create the necessary conditions for the best possible education for coming generations.

   e. to regulate family size because of its impact on the domestic economy.

(Reference 25, Continued)

Summary of Paragraphs, page 218:

The financial burden is shouldered by the government, as all family planning services are free of charge throughout the People's Republic of China.

People are encouraged to use birth control methods by being offered vacations, and are allowed to recuperate after abortion and sterilization procedures. For example, following an abortion the woman is given 2 weeks' paid leave from her work. After the insertion of an IUD, the women is given 2 days' leave with pay. When a man has a vasectomy, he is given one week off his job, with pay. After a woman has a tubal ligation, she is given 3 full weeks' pay.

Reference:

Chen, Pi-Chao: "China's Population Progress at the Grass Roots Level." Studies in Family Planning, Vol. 4, No. 8, Aug. 1973.

Summary of Paragraphs, page 219:

Planned birth in China is encouraged, along with delayed marriage and contraception. Induced abortion is not encouraged except as a last resort, when contraception fails to prevent unwanted pregnancy. Abortion is performed when birth control failure occurs, is usually a last resort, and is performed only on a voluntary basis.

One major obstacle to the spread of planned birth in the countryside has been the peasant's adherence to the traditional preference for male rather than female children. The government is continuing to do its best to condemn and combat this male chauvinism.

Chairman Mao's statement illustrates this change in attitude:

> "In the countryside the woman still wanted to have boy children. If the first and second children were girls, the mother would make another try. If the third one came and was still a girl, the mother would try again. Pretty soon there would be nine girls, and the mother would be 45 years of age. She would finally decide to leave it at that. This attitude must be changed, but it is taking time."

(Reference 27, Continued)

Summary of Paragraphs, pages 23-24:

The latest tactic in birth control in the People's Republic of China is "letting the masses draw up their birth plans and follow through." Local groups are drawing up their own birth plans, deciding how to meet their goals, taking responsibility for lowering fertility, and exerting peer pressure when applicable.

People are spacing births from 3 to 5 years apart. And the completed family size is two (or, sometimes in the country, three) children regardless of gender. Some public relation techniques used are film slide shows, broadcasts, exhibitions on family planning, and local public meetings.

Summary of Paragraphs, page 224:

Doctors, nurses, health workers, barefoot doctors, and midwives are used to disseminate and distribute birth control information to workers in the fields. Thus, birth control is brought to the workers, and they do not need to seek out services. Of course, it was found that this system decreases motivation on the part of the contraceptor.

Many cultural and institutional obstacles to family planning exist in the countryside in China. It has been a traditional and cultural norm to prefer male children, and to prefer large families. The roots of this preference lies in the traditional agrarian economic order. Male children represented increased assets, whereas the birth of a female child meant a drain on the already scarce resources.

Summary of Paragraphs, page 226:

The rationale for adopting planned births was as follows:

1. To better protect the health of mothers and children.
2. To better grasp revolution, increase production, and promote work.
3. To better support socialist construction.
4. To facilitate the cultivation of the next generation into proletariat revolutionary successors.
5. To follow an established policy of the state and the party.
6. To release more time and energy so as to creatively study and apply the thoughts of Mao.

(Reference 27, Continued)

Summary of Paragraphs, page 224 (Continued):

7. To support the world revolutions.

8. To increase the prosperity of the nation and state.

9. To improve labor participation and raise living standards.

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 74:

The Population Reference Bureau states seven reasons why family planning is so successful in the People's Republic of China. First, the desired number of children is two. Thus, people are socialized with the notion that there should be two children in the family. Second, women are free of their childbearing roles, and are now more able to pursue other careers from which they were previously excluded because of their frequent pregnancies. Third, postponed marriage and late marriage is encouraged. In late marriages, the couple tends to have children later, thereby delaying childbearing. Fourth, contraceptives are readily available, and free. Fifth, tubal ligation is well accepted by women, especially those 35 to 40 years of age, who already have two or more children. Sixth, people are motivated in terms of family planning because they feel that limiting their family size is their patriotic duty. Family planning posters stress the ideal family size as a father, mother, and two children. Loudspeakers provide family planning messages in villages and communes. Seventh, family planning is an integral part of the national health system. The health system is decentralized with local units, all of which approve family planning and birth control.

Reference:

Djerassi, Carl: "Fertility Limitation Through Contraceptive Steriods in the People's Republic of China." Studies in Family Planning, Vol. 5, No. 1, Jan. 1974.

Summary of Paragraphs, page 14:

Premarital intercourse is supposedly socially unacceptable as well as very rare. Also, the women with an illegitimate pregnancy or an unwanted pregnancy is encouraged to have an induced abortion.

At marriage, couples are given detailed advice about birth control. Married couples attend massive periodic meetings at various local levels, and hear speeches related to birth control, family planning, and delayed childbearing.

Summary of Paragraphs, page 16:

Djerassi states that birth control pills are the most popular form of birth control, that they are free and cannot be purchased. It is interesting to note the instruction for the use of oral contraceptive pills, which reads as follows:

"These tablets have been coated with sugar. Oral contraceptive pills have been prepared by the working class and scientific technicians under the thought of Chairman Mao. After several years of clinical experiments, they have proven to be almost 100% effective with no harm to the human body and will not cause damage to future fertility if usage and dosage are followed. The oral contraceptive is so far the best birth control method. Side Effects: a few women experience some side effects from the pill in the first couple of days. Some of these side effects are similiar to symptoms women experience in early pregnancy, such as nausea, dizziness, and depression and vaginal bleeding. Sometimes vomiting, tender breasts, decrease in milk supply, and skin rash may occur. The above side effects occur generally in the first month and may decrease gradually. Some of these side effects may not need treatment and will take care of themselves; otherwise, consult your physician."

Summary of Paragraphs, page 18:

Several forms of birth control used in the People's Republic of China are used either rarely or not at all, in the United States. One of these is a paper formulation of oral contraceptives, i.e., a sheet of water-soluable paper that dissolves in the mouth. The once-a-month pill is a high-dosage estrogen of the post-coital type. There is also the monthly injection which suppresses the periodic flow of eggs. This act of suppression prevents pregnancy.

Reference:

Chen, Pi-Chao: "China, the People's Republic of China." Studies in Family Planning, Vol. 6, No. 8, Aug. 1975.

Summary of Paragraphs, pages 223-224:

Educational and motivational work (sou-fu-fung-tso) emphasized the face-to-face approach through small group meetings and home visits where peer pressure can be more effectively exerted, rather than on impersonal communication through mass media.

The function of the barefoot doctor is to provide contraceptive knowledge and the contraceptives. He serves as the grass roots referral agency for the patient.

REPUBLIC OF THE PHILIPPINES

Reference:

Rubel, Arthur J.; Liu, William T.; Trosdal, Mimi; and Pato, Virginia: "The Traditional Birth Attendant in Metropolitan Cebu, the Philippines." Culture and Population: A Collection of Current Studies, Polgar, Steven, ed. Cambridge: Schenkman Publishing Co., Inc., 1971.

Summary of Paragraphs, page 183:

In Cebu, a province in the Philippines, the traditional birth attendant, or mananabang, uses two birth control methods. First, there is the manual manipulation of the female genital organs. The object is to tip the uterus or bend the fallopian tubes, thereby preventing the entrance of male semen and the passage of the ovum through the right side of the fallopian tube. There are no statistics as to the rate of effectiveness of this method. Second, if the woman experiences birth control failure, the mananabang can induce an abortion. First, she engages in hard external massaging of the pregnant woman's abdominal area. Then she presses increasing weights upon the pregnant woman's abdomen. Finally, with the ingestion of herbal infusions, the woman should abort.

Summary of Paragraphs, page 177:

The traditional birth attendant's rates are cheaper; it is more convenient to deliver at home in the neighborhood, and Pilipino women are modest and prefer women to care for them.

Summary of Paragraphs, page 184:

Pilipino women believe that fertilization and the initial period of gestation occur in the fallopian tube on the right side of the vagina.

Infertility or "barrenness" is attributed mainly to the women. The Pilipino in Cebu feels there are two main causes: (1) that the infertility is due to supernatural actions, or (2) that there is misplacement of the woman's generative organs, especially the uterus. It is interesting to note that the mananabang also massages and manually manipulates the uterus and abdomen to increase the woman's fertility.

Pilipino women experience some initial symptoms of pregnancy. The first is a craving for certain foods, especially the green mango. Second, they abstain from other specific foods. It is forbidden for pregnant women to eat octopus and specific fruits. No reasons or rationale were given in explanation of these cravings and restrictions of foods.

Reference:

MacCorquodale, Donald W.: "Pilipino Physician's Influence on Acceptor's Selection of the IUD." Studies in Family Planning, Vol. 5, No. 4, April 1974.

Summary of Paragraphs, Page 141:

MacCorquodale stated that a number of Pilipino family planning workers had observed that women of the lower socioeconomic class were reluctant to undergo a pelvic examination performed by a male physician. It seemed reasonable to assume that the observation might be valid, since the same behavior had been reported on the part of other Asian women.

Summary of Paragraphs, page 142:

Another interesting point is made by MacCorquodale in his article, "Pilipino Physician's Influence on Acceptor's Selection of the IUD." He states that a number of studies have suggested that the IUD prevents pregnancy by preventing implantation of the fertilized ovum. Physicians could interpret this as meaning that the IUD produces a micro-abortion which might be less acceptable to some Roman Catholics than use of the oral contraceptive.

Reference:

Laing, John E.: "Differentials in Contraceptive Use-effectiveness in the Philippines." Studies in Family Planning, Vol. 5, No. 10, Oct. 1974.

Summary of Paragraphs, page 304:

Laing stated two major reasons most commonly given for discontinuing use of the first method of birth control used: (1) the side effects, and other medical reasons; and (2) birth control failure, or accidental pregnancy.

Reference:

Baretto, Felisa R.: "Knowledge, Attitudes and Practice of Family Planning in the Philippines." Studies in Family Planning, Vol. 5, No. 9, Sept. 1974.

Summary of Paragraphs, page 296:

Traditionally, in the Philippines a large family is the rule rather than the exception, and the current normal family size is three or four children. The level of approval for family planning is higher in the urban than in the rural areas. There are several reasons for the disapproval of family planning. The Knowledge, Attitudes and Practice (K.A.P.) survey in 1972 in the Philippines revealed that 28 percent of the women disapproved of family planning because of the possible danger to their health; 24 percent, because of moral or religious objections; 17 percent, because of the disapproval of their husbands; 9 percent, because of the desire for a large family; 7 percent, because it was too much trouble or inconvenience; 7 percent, because of the expense; and finally, 5 percent, because of its effect on the sexual act. Rhythm was approved both for oneself and for others more often than any other method. The pill, IUD, and withdrawal, in that order, followed in degree of approval.

Reference:

Little, Arthur D., Inc.: "Commercial Distribution of Contraceptives in Colombia, Iran, and the Philippines." Reports on Population and Family Planning, Population Council of New York.

Summary of Paragraphs, pages 22-23:

The Little report cited three major barriers to use of contraceptives by Pilipino women. First, the cost of birth control methods is a major barrier. Many women cannot afford to buy contraceptives. Approximately 20-60 percent of the population in the Philippines is reported to live and die without ever seeing a doctor.

Second, the Catholic Church has exerted a strong influence on women against the use of contraceptives. The Church's only affirmative effort in family planning is to support Church-sponsored institutions and clinics which advocate the rhythm method.

Third, the Philippine Medical Association (PMA) acts as a strong barrier to women's use of family planning. Earlier, PMA discouraged the dissemination of information on contraceptives by drug companies, but currently their attitudes have become more liberal. There is an increasing concern in the PMA regarding non-prescription availability of oral contraceptives. PMA is apprehensive about allowing nurses or paramedical personnel to dispense oral contraceptives. Yet, if family planning is to reach the barrios
and the outlying regions of the cities, more health workers must be mobilized, because doctors cannot bear the full burden.

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 94:

According to the report on world population growth and response, the population of the Philippines has one of the highest growth rates in Asia and in the world. Recently, the government changed from encouraging population to limiting fertility. The government at one point felt that an increased population could develop and live in the uninhabited outlying lands in the Philippines. That perspective changed when the population rate increase continued to rise so rapidly.

Several reasons led the government to change its population policies. First, the educational system was becoming taxed beyond its limit, with an increased number of people. Second, there was a limited amount of food for an increasing number of people, third, the health services and sanitation began to become inadequate for the population served.

The Philippine government has instituted several reinforcements to incentives for the Pilipino people to control population rates and use family planning. In 1971, the Population Act made birth control methods, with the exception of abortion and sterilization, available to everyone. The Labor Code required employers to provide free family planning services to their workers. The government law, which formerly had favored large families, was rescinded, and a new income tax law, which favored small families, was instituted. Finally, all persons intending to get married had to show proof that they had received family planning counseling.

SINGAPORE

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 98:

The government has initiated a series of disincentives for large families. Policies include limiting maternity and tax relief benefits and other types of assistance. Singapore encourages family planning in several ways:

- No anti-contraceptive legislation exists.
- IUD's, oral contraceptives, and condoms are available at a low cost.
- Abortion laws have been liberalized.
- Sterilization is free
- Information, education, and programs on family planning concentrate on schools, places of work, and the community at large.
- Childless couples find public housing readily available.
- Employed women with three or more children find it hard to get maternity privileges.

In terms of popularity, first the pill, and second the condom, are the most popular contraceptive devices.

SOUTH KOREA

Reference:

Song, Kun Yong: "Attitudes Toward Family Planning, Marriage, and Family Size Among Unmarried Women in Korea." Studies in Family Planning, Vol. 6, No. 10, Oct. 1975.

Summary of Paragraphs, page 372:

Today, young unmarried Korean women are more independent of the influence of their families. There is a tendency for them to participate actively in choosing a spouse, and they are more concerned than in the past with such factors as the income, education, occupation, and military status of a prospective husband.

Summary of Paragraphs, page 373:

The mean desired number of children is 2.6 children per family. Fifty-five percent of the women in Kun Yong Song's survey wanted their first child to be a boy. The national slogan in Korea for family planning is "Daughter, son without distinction; stop at two and raise them well."

Summary of Paragraphs, page 374:

According to Kun Yong Song's survey (in terms of spacing births) 69 percent of young women preferred to have their first child within the first 2 years of marriage, and 38 percent preferred to wait until the second year to have their first child. When asked in the survey when they should start using a birth control method, 11 percent of the Korean women responded that they wished to start at the onset of marriage; 24 percent wanted to wait until after their first child; 24 percent wanted to wait until after their second child; 20 percent wanted to wait until after their third child; 18 percent did not know; and 3 percent disapproved of the use of contraceptives altogether.

When the same women were asked two ways to have the desired number of children, 48 percent wanted to have the desired number of children promptly and then terminate their childbearing early; 44 percent of the women wanted to have children slowly by spacing births.

The women were asked the possible benefits of family planning. Answers revealed that they used contraceptives to provide better care and education for their children; to relieve economic concerns; to promote better health for mother and child; and to achieve a better married life. Induced abortion for married women was acceptable to 36 percent of all respondents.

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, pages 85-86:

The Korean government has taken some steps to encourage family planning. Some of the recent steps have been as follows:

- Strong emphasis has been shifted from the IUD to oral contraceptives, sterilization, and condoms.
- The legal restrictions on abortion and menstrual regulation have been eased.
- As previously mentioned, the government program adopted the slogan, "Daughter, son without distinction; stop at two, and raise them well."
- Efforts have been made to overcome the traditional preference of Korean parents for boys, and their desire to have two sons.
- The ban on advertising oral contraceptives in the mass media was lifted.
- A new law allows trained nurses and midwives to insert IUDs, and provides them with an extended nursing role similar to that of nurse practitioners in the United States.

Reference:

Park, Hyung Jong; Kincaid, D. Lawrence; Chung, Kuyng Kyoon; Lee, Sea Baick; and Ha, Dal Sun: "Korea's Mother's Club Program." Studies in Family Planning, Vol. 7, No. 10, October 1976.

Summary of Paragraphs, page 282:

In Korea, there is a unique type of nontraditional outreach called the "Mother's Club Program." The Mother's Club Program was established for several reasons:

- It gave women an officially sanctioned public forum for discussion of mutual concerns (i.e., birth control) without the shame and secrecy of the past.
- Field workers could openly teach a group of interested women about birth control.
- The negative side effects of birth control could be discussed.

(Reference 21, Continued)

Summary of Paragraphs, page 282 (continued):

- Members of the Mother's Club Program could decide to go to the clinic in groups to encourage each other to follow through with the procedures and birth control methods.

- Successful mothers could explain to others how they persuaded their husbands to accept family planning.

Summary of Paragraphs, page 276:

The Mother's Club Program also served the purpose of encouraging family planning practice and continuation by example, giving social and emotional support to those who accepted birth control. It also aided overburdened field workers in recruiting new accepters of family planning. A practice of the program was to supply birth control pills, condoms, and other contraceptives, thereby bringing birth control to the person instead of having the person seek a method at a clinic. Finally, the program aided in the introduction of a new birth control method.

The two main strategies of the Mother's Club Program were (1) to accelerate interpersonal communication in regard to family planning, and (2) to legitimize family planning practice among rural women in Korea.

Summary of Paragraphs, page 275:

In a traditional Korean village, there was a council that conducted all village business. Women were traditionally excluded from direct participation in the council, and were in the role of the passive person who did not take much initiative outside her home or family affairs.

Summary of Paragraphs, page 282:

Recently, under the Korean Mother's Club Program, women have formed groups of their own which talk openly about contraception. This is a far cry from the situation of older village mothers who had to practice contraception secretly to avoid severe criticism or even beatings by their own husbands.

Reference:

Palmore, James A.; Furlong, Michael J.; Park, Insook Han; Aouder, Laura; and Buchmeier, Francis S.: "Family Planning Opinion Leadership in Korea." Studies in Family Planning, Vol. 7, No. 12, Dec. 1976.

Quotation from page 349:

"Korea's National Family Planning Program has been widely touted as one of the world's most successful. Undoubtedly, this success is due partly to an early reliance on interpersonal communication as a major mechanism for influencing Korean women to adopt contraception."

SOUTH VIETNAM

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 103:

The major handicap of family planning services in Vietnam has been the existence of a long-standing law, imposed under French rule, that restricts dissemination of contraceptive materials and information. In 1971, however, the World Health Organization (WHO) project stressed the importance of family planning in securing a higher standard of living for the family as a whole.

TAIWAN

Reference:

Hermalin, Albert: "Empirical Research in Taiwan on Factors Underlying Differences in Fertility." Studies in Family Planning, Vol. 5, No. 10, Oct. 1974.

Summary of Paragraphs, page 316:

Hermalin's article suggests that as with many of the Asian countries that have steadily been gaining economic wealth and have been increasing industrially, there could be economic factors in Taiwan that underlie differences in fertility. He points out "that many of the currently industrialized countries reduced their fertility during periods of rising incomes," and has suggested that "the desire to take advantage of emerging opportunities acts as a deterrent to fertility."

Reference:

Anderson, John E. "The Relationship Between Change in Educational Attainment and Fertility Rates in Taiwan." Studies in Family Planning, Vol. 6, No. 3, March 1975.

Summary of Paragraphs, page 72:

Anderson states that there is a "close relationship of decreasing fertility to one important dimension of modernization--increasing levels of educational attainment. For Taiwan, a fairly consistent relationship between low education and high fertility has been found."

Reference:

Chow, L.P.: "Family Planning in Taiwan, Republic of China: Progress and Prospects." Population Studies, Nov. 1970.

Summary of Paragraphs, page 340:

In Taiwan, several financial reinforcements and monetary incentive systems are used to strengthen acceptance of birth control methods. A coupon system was established to increase women's motivation toward birth control. Home visits and small group meetings have been the two major approaches of the field workers. Coupons are issued to women who show interest in the Loops (IUDs). The coupon entitles the holder to a discount of 50 percent of the cost of insertion, which includes aftercare and follow-up.

Reference:

Wang, C.M.; and Chen, S.Y.: "Evaluation of the First Year of the Educational Savings Program in Taiwan." Studies in Family Planning, Vol. 4, No. 7, July 1973.

Summary of Paragraphs, page 157:

Taiwanese parents who limit their family size to two children received free birth control services, and their children's full tuition to high school was paid. As the number of children increased to three, only one half of the high school tuition was paid for all three children. When the family increased to four children, no tuition was paid for any of them. Thus, to couples who limited their fertility, the program provided funds for their children to attend high schools, technical schools, or universities.

Reference:

Su, I.H.; and Chow, L.P.: "Induced Abortion and Contraceptive Practice: An Experience in Taiwan." Studies in Family Planning, Vol. 7, No. 8, Aug. 1976.

Summary of Paragraphs, page 224:

A study was made in Taiwan to determine the attitudes of Taiwanese women toward birth control following an abortion. Researchers Su and Chow felt there were "two possible learning effects" following an abortion. One was a positive effect in which the woman learned from the unpleasant abortion experience, did not wish to become pregnant again, and therefore chose to use contraceptives. The second was a negative effect in which the woman did not use a birth control method, became pregnant, aborted, and then used abortion as a birth control method, because the abortion was not as hard or as difficult as she originally had expected.

If the woman had used a birth control method prior to the abortion and experienced birth control failure, she continued to use a birth control method after the abortion. If the woman did not use a birth control method and became pregnant, she continued to have unprotected intercourse and did not use contraceptives. Instead, she resisted use of a birth control method and used abortion to terminate her unwanted pregnancies.

Su and Chow found that after a first abortion 33 percent of the women used a birth control method, whereas after a third abortion, 60 percent of the women used a birth control method. This still left a surprisingly high percentage (40 percent of those women who had had their third abortion) who were not using contraceptives.

(Reference 40, Continued)

Summary of Paragraphs, page 224 (Continued):

The women with a higher educational level tended to have a positive learning effect after their abortions. They felt strongly that after any abortion, regardless of how many a woman has had, all possible efforts should be made to reach the woman and motivate her to use a birth control method.

Reference:

Population Reference Bureau, Inc.: World Population Growth and Response 1965-1975: A Decade of Global Action. Washington, D.C., 1976.

Summary of Paragraphs, page 77:

Three additional forms of outreach are used to encourage and motivate Taiwanese women to use family planning: (1) family planning workers refer potential accepters to the doctor, to the hospital, and to health stations; (2) mass communication is used extensively to promote interest and participation in family planning; and (3) family planning field workers visit all wives who are 30 years and older who have achieved their desired family size.

In terms of popularity, the IUD is the main form of birth control in Taiwan.

Reference:

Cernada, Eleanor Ching-Ching; Lee, Yang Jai; and Lin, Mei-Yuan: "Family Planning Telephone Services in Two Asian Cities." Studies in Family Planning, Vol. 5, No. 4, April 1974.

Summary of Paragraphs, page 114:

In addition, Taiwan and Korea utilized a telephone answering service which proved to be an inexpensive and effective means of providing counseling, referral, and information on family planning, birth control, and sexual matters.

THAILAND

Reference:

Knodel, John; and Pitaktepsombati, Pichit: "Thailand: Fertility and Family Planning Among Rural and Urban Women." Studies in Family Planning, Vol. 4, No. 9, Sept. 1973.

Summary of Paragraphs, page 230:

Until recently, Thailand's official stance on population was predominantly pronatalist, under the assumption that quantity could be equated with strength. One major reason for setting up a public health service in 1914 was to increase the rate of population growth by reducing mortality. During World War II, early marriages were encouraged, and as of 1956, bonuses were offered for large families.

Comments:

There are strong implications that the above-mentioned influences still hold for Thai immigrants in America. The history of governmental encouragement and monetary reinforcement in the form of bonuses is probably being carried over. Thai families may continue to be large. Women may not use birth control methods, and because economic conditions in the United States are different from those in their Thai homeland, it may be difficult for them to eke out a living with such a large family.

Public relations is an important area of concern for the Asian/Pacific person in terms of family planning services. Many vernacular newspapers are published in the language of each Asian/Pacific group; yet because of the English language barrier that many Asian/Pacific people face, they are unable to obtain family planning services. The family planning brochures are printed in English and the Asian/Pacific women are unaware of services available to them.

Reference:

Rosenfield, Allan G.; Asavasena, Winich; and Mikhanorn, Jumroom: "Person-to-Person Communication in Thailand." Studies in Family Planning, Vol. 4, No. 6, June 1973.

Summary of Paragraphs, page 146:

One excellent example of public relations was an article entitled, "Person-to-Person Communication in Thailand." Word-of-mouth communication proved to be an effective public relations method in Thailand during a period of time when the Thai government restricted all forms of family planning advertisement. Amazingly enough, the Chulalongkorn Program increased its family planning patient load from 57,3000

(Reference 41, Continued)

Summary of Paragraphs, page 146 (Continued):

in 1968 to 404,187 in 1971. In 3 years' time, the patient load had increased 346,887! Women had come from 66 of Thailand's 77 provinces. The family planning program did not use any form of public relations, advertisement, or media announcement, yet the patient load kept growing. Later, it was discovered that the majority of women who came for services "heard about the services from friends and relatives or, to a lesser degree, from health personnel."

Summary of Paragraphs, page 149:

This aspect of word-of-mouth communication is vital in the Asian/Pacific culture. Because of the fact that many Asian/Pacific people came from a background of rural and village life, and have strong kinship ties, person-to-person communication is an important referral system for the Asian/Pacific community. And, as Rosenfield states, there is "no better advertisement than a satisfied acceptor of family planning services."

Reference:

Porapakkham, Yawarat; Donaldson, Peter J.; and Svetsreni, Thavisak: "Thailand's Field-Worker Evaluation Program." Studies in Family Planning, Vol. 6, No.7, July 1975.

Summary of Paragraphs, page 201:

Recently in Thailand, family planning has been integrated into the health services network. The family planning field workers now concentrate on motivational activities to increase the client load and client participation.

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APPENDIX A

BACKGROUND INFORMATION ON SPONSORING ORGANIZATIONS

APPENDIX A

BACKGROUND INFORMATION ON SPONSORING ORGANIZATIONS

The three organizations responsible for developing, funding, and staffing the Asian Women's Health Project were T.H.E. Clinic for Women, Inc., Los Angeles Regional Family Planning Council (LARFPC), and the Asian American Studies Center at the University of California, Los Angeles.

1. T.H.E. Clinic for Women, Inc.

T.H.E. Clinic for Women, Inc., is a private nonprofit corporation in operation since 1974. The clinic is located in the Southwest Health District, Central Health Services Region, Los Angeles County.

The clinic focuses on direct medical services in gynecology, obstetrics, counseling services, and education. At the present time, the family planning program accounts for 70 percent of the clinic's overall program. The clinic handles 7,500 patient visits per year.

Since 1976, one special area of service within the family planning component has been providing help to the Asian/Pacific population within the general Los Angeles area. Work by T.H.E. Clinic staff with Asian/Pacific health professionals has highlighted the growing need for family planning services to these communities.

In 1977, in response to this growing involvement in the family planning needs of Asian/Pacific women, the clinic proposed to LARFPC that a study be made to investigate the relationship between family planning needs and the cultural traits distinctive to Asian/Pacific women in Los Angeles County; and that the study provide a model on which to base funding for the delivery of family planning services to Asian/Pacific communities in the Los Angeles area.

As a result of the proposal, the Asian Women's Health Project was funded by LARFPC, with additional financial support from the UCLA Asian American Studies Center.

A community advisory group, known as the Asian Women's Health Project Task Force, provided consultation and overall review of the project. The task force was composed of health providers, community workers, and consumers from various Asian/Pacific communities.

Specifically, the role of the task force was fourfold:

- To provide input regarding direction of the project.
- To share expertise in needed areas (e.g., community assessment, requirement for special knowledge of particular Asian groupings).
- To work with the staff on the final recommendations, as well as to consult with staff during the project period.
- To share resources when possible (community contacts and informational materials).

Members of the task force were as follows:

Lillian Fabros, Pilipina Social Worker
Pacific Asian Elderly Research Project

Arlene Kushida, Japanese American Research Analyst
Asian American Training Center

Dr. Myoung Hee Min, Korean Family Planning Consultant
Koryo Health Foundation

Ngoc Pham, Vietnamese Community Counselor
Asian Community Service Center

Adele Satelle, Samoan Psychiatric Social Worker
Asian Pacific Counseling Center

Gary Uyekawa, Japanese American Physician's Assistant
House of Uhuru (Drug Rehabilitation Program)

Yvonne Wong, Chinese Teacher of English as a Second Language
Chinatown Committee for Social Services, Inc.

Yoneo Yamamoto, Japanese American Asian Liaison
Los Angeles County Department of Health Services, Community Relations
313 North Figueroa St., 6th Floor
Los Angeles, California 90012

Activities of the project included a 4-hour seminar, held at LARFPC headquarters for family planning specialists (see Exhibit 3). A presentation of the preliminary findings of the project was made to the National Convention of the American Public Health Association. The convention was held at Los Angeles in October 1978.

In addition, the project staff was called upon to conduct numerous presentations and lectures on the initial findings of the project and the general subject of Asian/Pacific women and health. A number of requests for articles and papers also were received from various community and academic publications, and health journals.

2. Los Angeles Regional Family Planning Council (LARFPC)

The Los Angeles Regional Family Planning Council (LARFPC) is a non-profit California corporation organized in 1968 to further the development and coordination of family planning services throughout Los Angeles County. LARFPC receives grants from the U.S. Department of Health, Education, and Welfare, Bureau of Community Health Services, and contracts from the California State Department of Health, Office of Family Planning. The County of Los Angeles contributes directly to the program by supporting health center and hospital services. In 1978, the total LARFPC program had a dollar scope of approximately $13,500,000.

As an administrative and planning agency, LARFPC contracts with health institutions for delivery of medical care and support services. LARFPC-supported family planning services are provided at nearly 100 clinic locations throughout the County of Los Angeles, with at least one site in every one of the County's 25 health districts.

Four types of health care providers compose the LARFPC Countywide network. Medical centers (both private and County hospitals) care for 29 percent of the patients; community clinics, 24 percent; family planning corporations (planned parenthood programs), 23 percent, and County neighborhood health centers, 24 percent.

3. Asian American Studies Center

Established in 1969, the Asian American Studies Center is one of four ethnic studies centers on the campus of the University of California, Los Angeles (UCLA). Programs and activities of the center are organized under four broad areas of emphasis: curriculum development, resource development and publications, student/community projects, and research.

The center offers courses through various UCLA departments and the College of Letters and Sciences. It also provides administrative support for both the undergraduate major in East Asian Studies and the M.A. degree program in Asian American Studies. The M.A. program is the only graduate program of its kind in the United States.

The center assists student groups in securing funding for student programs. It also coordinates student efforts in community service projects such as tutoring, conduct of health programs, alien registration drives, urban redevelopment projects, and media presentations.

The center agreed to cosponsor the Asian Women's Health Project as a part of its ongoing research activity. The center supported the project through the assignment of a half-time research assistant, consultation on the project's development, and assistance in identifying materials and resources used by the project staff.

APPENDIX B

PREPARATORY QUESTIONS FOR THE ASIAN WOMEN'S HEALTH PROJECT

Asian Women Health Center

PREPARATORY QUESTIONS FOR THE ASIAN WOMEN'S HEALTH PROJECT

1. What are some of the general characteristics of the _____ community?

   A. Class background, makeup
   B. Types of employment
   C. Geographic concentration
   D. Percentage of single adults
   E. Age breakdown
   F. Sex breakdown
   G. Size of family, extended family situation
   H. Level of income
   I. Length of residence
   J. Relationship to other Asians, Third World people, majority culture people
   K. Any cultural particularities
   L. Main problems or issues as a community

2. Do you feel there are cultural barriers preventing _____ women (and men) from being open to receiving, or learning about, family planning methods?

3. Do the low-income women of your community receive, or know where or how to receive, adequate health care--in particular, family planning care?

   - If not, what do you feel may be some of the barriers preventing the women from receiving this care?
   - If so, where do they receive these services?

4. How much knowledge do you feel that women from the community have regarding their health in general, and family planning in particular?

5. Is there a relationship between the amount of knowledge of health care and family planning and:

   - income level?
   - length of residence in the United States?
   - age?
   - sex?
   - religion?
   - other?

6. Are most of the women you see recent immigrants?

7. Are there community organizations and service groups in _____ community?

   - Do these organizations provide for the health needs of women, or provide ancillary services? followup services?

APPENDIX C

ASIAN WOMEN'S HEALTH PROJECT
SURVEY QUESTIONNAIRE

ASIAN WOMEN'S HEALTH PROJECT SURVEY

NAME: _____

TITLE: _____

AGENCY: _____

ADDRESS: _____

_____

PHONE: _____

DATE OF INTERVIEW: _____

1. What was your average F.P. patient load over the last 6 months?

What was your average F.P. patient load over the last year?

How many of these were Pacific/Asians (P/A)?

2. Have you done a demographic survey or needs assessment of the P/A community in your general service area? Yes-No

What specific F.P. needs do you see for the P/A community?

Do you know if there is a P/A community in your general service area?
Yes-No

3. Which of the P/A ethnic women's groups demonstrated the greatest need for F.P.?

_____ Japanese	_____ Vietnamese	_____ Hawaiian
_____ Chinese	_____ Cambodian	_____ Korean
_____ Thai	_____ Pilipino	_____ Laotian
_____ Guamanian	_____ Samoan	_____ Other

_____ Newly immigrated	_____ 19 - 24 years	_____ 45 - 54 years
_____ 11 - 14 years	_____ 25 - 34 years	_____ 55+ years
_____ 15 - 18 years	_____ 35 - 44 years	

4. Have any of the following been observed as barriers to P/A women receiving F.P. services?

a. Lack of transportation? Yes-No

1) Is public transportation within 1-2 block radius of your facility? Yes-No

b. Inaccessibility to facility? Yes-No
Lack of awareness of availability? Yes-No

1) Do you have bilingual signs? Yes-No

2) Number of signs: _____

3) Location of signs?

4) Content of signs:

5) How does the P/A community know and find out about your facility?

6) Do you get referrals for P/A women for F.P. services? Yes-No

7) From whom?

c. Cultural isolation? Yes-No Cultural differences? Yes-No

1) Have you noticed any hesitation on the part of the P/A woman in being treated by a non-P/A, or male health care provider? Yes-No

2) Do you feel P/A women are embarrassed when receiving F.P. services, more so than other women? Yes-No

3) Have you noticed any special needs, cultural needs, cultural differences, or special attitudes toward F.P. services in P/A women? Yes-No

Please elaborate:

4) Have you received or solicited any feedback from the P/A women who utilize your facility? Yes-No

d. Language barrier? Yes-No

1) What P/A languages are available at your facility?

2) Number of bilingual P/A staff, and their jobs:

3) Are any P/A bilingual consent forms available? Yes-No
May we have a copy?

4) If no P/A translator is available, what is done?

a) Referral system available? Yes-No

b) To whom are they referred?

c) Dictionary with key P/A medical terms available? Yes-No

Would this dictionary be useful for your facility? Yes-No

d) Other:

5) Are you aware of any health education information or literature in P/A languages that are available? Yes-No

May we have a copy?

e. Cost of services? Yes-No

1) Do most P/A women qualify for state-subsidized (Medi-Cal, etc)., F.P. services? Yes-No

2) Do most P/A women receive F.P. subsidies? Yes-No

3) Are P/A women on a fee for service scale? Yes-No

f. Lack of knowledge or ignorance about F.P.? Yes-No

1) Do you feel special F.P. educational programs are needed for P/A women? Yes-No

2) Can you suggest any special attempts useful for P/A women to increase F.P. awareness?

3) Do you think P/A women are knowledgeable about various preventive screening tests? Yes-No

4) Do you think P/A women lack the knowledge and experience in using your health facility? Yes-No

Why?

5. Are the above problems (barriers) specific to P/A women? Yes-No

Why?

6. Improving F.P. services to P/A women:

a. Do you have any plans for improving F.P. services to P/A women? Yes-No

b. Could the AWHP assist you in this? Yes-No

How?

c. How could LARFPC reach out to P/A women?

d. Suggestions on projects/public relations/materials to be developed

e. Are you interested in in-service training for your staff on the P/A community? Yes-No

f. Have you had any in-service, or cultural sensitivity training, or sessions on the special needs of P/A clients? Yes-No

g. Would you like assistance in this? Yes-No

How?

7. Do you have any contacts with P/A women's groups or community groups? Yes-No

Which ones? and for what purposes?

8. Have you attempted to recruit bilingual P/A staff? Yes-No

Have you had difficulty in locating bilingual staff? Yes-No

Would you like assistance with recruiting P/A bilingual staff? Yes-No

What was the method used to recruit bilingual staff?

9. What are your funding sources?

10. How does your facility provide services for F.P.?

a. Appointment basis? Yes-No

b. Schedule of payment for services?

c. Phone referral? Yes-No

d. Staff?

W.H.C.S.

N.P.

Ob-Gyn M.D.

Other

e. Recommendations to increase utilization of F.P. services to P/A women:

f. Improvements in the existing F.P. services now offered by your facility:

11. Would it be valuable to hold a P/A women's special clinic? Yes-No
(Like the teen clinics)

12. Services provided: GET A BROCHURE FROM FACILITY:

1. ask if there are any changes
2. additional services
3. services no longer available

_____ routine gynecological exam

_____ cancer screening, breast, pap smear

_____ urinalysis

_____ blood pressure screening

_____ VD screening and treatment

_____ pregnancy testing

_____ F.P. services, birth control, and instruction

_____ prenatal care

_____ premarital blood testing

_____ vaginal, pelvic, and urinary tract infection care

_____ counseling--problem pregnancy, abortion, marital, family

_____ health education, presentations to the community, LaMaze classes

_____ services for men--VD screening, blood testing

_____ referral services

_____ rape services, rape counseling

_____ sterilization

_____ abortions

13. Additional comments/suggestions:

THANK YOU VERY MUCH FOR YOUR COOPERATION AND TIME IN TAKING THIS SURVEY.

Asian Women's Health Project
T.H.E. Clinic for Women
3860 W. Santa Barbara Ave.
L.A., CA. 90008

(213) 295-6571 ext. 24
Miya Iwataki
Teresa Takaki

APPENDIX D

FACILITIES, ADMINISTRATORS, AND PRACTITIONERS SURVEYED FOR ASIAN WOMEN'S HEALTH PROJECT

LARFPC AGENCY SURVEY:

Agencies Surveyed

I. Hospitals and Community Programs

A-1. County Hospitals

Los Angeles County Harbor/UCLA Medical Center Hospital

John Wesley Hospital

A-2. Non-County Hospitals

California Hospital Medical Center

Cedars-Sinai Medical Center

B-6. Community Programs

Chinatown Service Center

Koryo Health Foundation

T.H.E. Clinic for Women, Inc.

II. Family Planning Corporation

Mar Vista Planned Parenthood

Planned Parenthood, World Population

III. Los Angeles County Clinics

Southwest Health District

Hollywood-Wilshire Health District

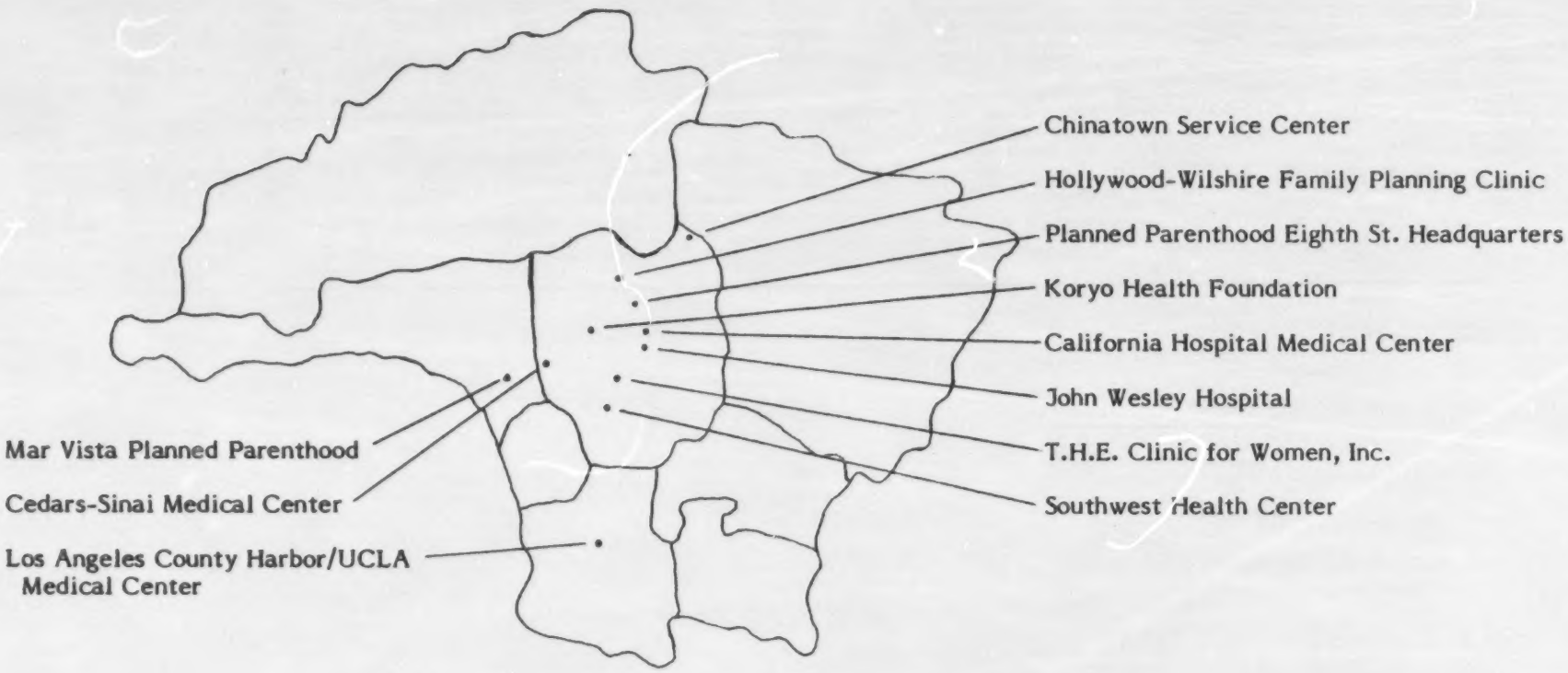
INTERVIEW SCHEDULE

Administrators	Date
Irene Hirano, Executive Director T.H.E. Clinic for Women, Inc.	May 18, 1978
Ann Bridges, Project Director John Wesley Hospital Family Planning Clinic	June 5, 1978
Audrey Purvis, O.P.D. Administrator California Hospital Family Planning Clinic	June 9, 1978
Nancy Schuetz, Program Administrator Cedars-Sinai Family Planning Clinic	June 9, 1978
Crystal Span, F.P. Coordinator Mar Vista Planned Parenthood	June 15, 1978
Cathy Dirks, Program Administrator Los Angeles County Harbor/UCLA Medical Center	July 7, 1978
Sallie Carlos, Program Administrator Gloria Escamillo Planned Parenthood World Population	August 22, 1978
Dr. Han Koryo Health Foundation Family Planning Clinic	October 13, 1978

Interview Schedule

Practitioners	Date
Erlinda Roja, RN Muriel Koeller, NP John Wesley Hospital Family Planning Clinic	June 5, 1978
Dr. Joseph Cheung California Hospital Family Planning Clinic	June 9, 1978
Dr. Pauline Berstein Cedars-Sinai Family Planning Clinic	June 9, 1978
Christina Hsu, Family Planning Outreach Worker Chinatown Service Center	June 14, 1978
Debbie Herczog, NP Mar Vista Planned Parenthood	June 15, 1978
Dr. Portia Choi Southwest Health District Family Planning Clinic Hollywood-Wilshire Health District Family Planning Clinic	June 17, 1978
Sharon Syverson, NP Harbor General Hospital Family Planning Clinic	July 7, 1978
Day Suehiro Sato, WHCS T.H.E. Clinic for Women, Inc.	August 1, 1978
Cathy Wong, RN John Wesley Hospital Family Planning Clinic	August 14, 1978
Chris Ichikawa, NP L.A. Harbor College, Nursing School Los Angeles County Harbor/UCLA Medical Center	August 22, 1978
Fran Goldfarb, Outreach & Education Coordinator Planned Parenthood World Population Family Planning Clinic	August 22, 1978
Dr. Min Koryo Health Foundation Family Planning Clinic	October 9, 1978

LOCATIONS OF LARFPC FAMILY PLANNING CLINICS SURVEYED WITHIN LOS ANGELES COUNTY



APPENDIX E

CONSUMER SURVEYS FOR ASIAN WOMEN'S HEALTH PROJECT

ASIAN/PACIFIC WOMEN'S HEALTH PROJECT

Contact person _____

Ethnic Nationality _____

Age _____

Marital Status _____

Number of Children _____

Geographic Area _____

Type of Employment _____

Educational Level _____

Languages(s) Spoken _____

Religion _____

Length of Residence in U.S. _____

1. Do you get regular health check-ups? a. Yes b. No

   Have you ever received a pap smear? a. Yes b. No c. When _____

   Have you had a breast examination? a. Yes b. No c. When _____

2. Have you (or your boyfriend/husband) ever used any method to prevent or postpone a pregnancy or a birth? a. Yes b. No

   If yes, what methods have you used?
   a. Pills
   b. Condoms
   c. I.U.D.
   d. Foam
   e. Diaphragm
   f. Withdrawal
   g. Rhythm method
   h. Other, please specify _____

Are you familiar with methods other than the one you've used?

a. No b. Yes c. If yes, please specify _____

3. Who do you go to when you need medical help?
   a. Husband/boyfriend
   b. Parents
   c. Friends
   d. Priest/Minister
   e. Doctor/health worker
   f. Social worker of your nationality
   g. Other, please specify _____
   h. I have no one to go to

4. Are there other health problems or questions that have been troubling you?

_____

_____

_____

5. Where do you go when you need health services? _____

_____

_____

How do you pay for these services? _____

_____

Are there people who speak your language there? a. Yes b. No

6. Do you have difficulty seeking good health care? a. Yes b. No

If yes, why?
- a. The doctors do not speak my language
- b. I cannot afford the care
- c. I have no transportation
- d. I do not know of any facilities
- e. Other, please specify _____

_____

7. If a clinic or hospital in your neighborhood had a health worker who spoke your language, would you go there? a. Yes b. No c. Doesn't Matter

Would you prefer the health worker to be a woman? a. Yes b. No c. Doesn't Matter

Would you be more comfortable with an Asian/Pacific health worker? a. Yes b. No c. Doesn't Matter

8. What is the main problem your people face (i.e., health, language, immigration, job)?

_____

_____

9. What kind of health education do you need or want? _____

_____

_____

親愛的朋友：

謝：您撥冗回答這份亞洲婦女健康計劃的問卷調查。這份問卷調查的目的是為了要增加亞洲婦女健康計劃對亞洲籍及太平洋諸島婦女需要的瞭解。我們還同時訪問了許多亞洲籍及太平洋諸島的社會工作者、社區和醫療工作人員、醫生、和一些應該為社區提供醫療服務的醫院和診所。這份問卷資料對我們日後計劃發展社區雙重語言及文化的醫療服務將會有很大的幫助。在這份問卷上，您不需要具名；對您所提供的資料，我們也保証絕對地守密。

謝、您的幫忙和合作。

亞洲/太平洋婦女健康計劃

聯絡人 _____

種族/國籍 _____
年齡 _____
婚姻狀況 _____
子女數目 _____
地理(住區)分佈 _____
職業 _____
教育程度 _____
日常所用語言 _____
宗教信仰 _____
在美居留年數 _____

1 你有沒有作定期身體檢查? a 有 b 沒有
你有沒有作過子宮頸片檢查(pap smear)? a 有 b 沒有
c (如果有)什麼時候作的 _____
你有沒有作過乳部檢查? a 有 b 沒有 c (如果有)什麼時候作的 _____

2 你(或者你的男朋友或丈夫)有沒有用過任何方法來阻止或避免你的懷孕或生產?
a 有 b 沒有
如果有,你用的是什麼方法?
a 避孕藥 (pills)
b 陰莖套 (condoms)
c 子宮環 (I.U.D.)
d 泡沫劑—避孕片劑 (Foam)
e 陰道隔膜—俗稱子宮帽 (Diaphragm)
f 體外排精 (withdrawal)
g 安全期避孕法 (Rhythm method)
h 其他,(請說明) _____

你知不知道除了你所用過的方法之外的其他方法?
a 不知道 b 知道 c 如果知道,請說明是什麼方法 _____

3. 當你需要幫助時,你會向誰求助?
a 丈夫/男朋友
b 雙親
c 朋友
d 牧師
e 醫生/健康醫療人員
f 同種族團體的社會工作者
g 其他,請說明 _____
h 我沒有人可以求助

4 除了前面所提到的問題，還有沒有其他的問題在困擾你呢？

_____

_____

5. 當你需要醫療服務時，你會到那兒去呢？_____

_____

你怎麼去支付這些醫療費用呢？_____

在這些醫療服務的地方，有沒有會說你懂得的語言的工作人員？ a. 有 b. 沒有

6. 你有沒有困難找到好的醫療服務？ a. 有 b. 沒有

如果有，為什麼？

a. 醫生不會說（或不懂）我說的語言
b. 我付不起醫療費
c. 我沒有交通工具
d. 我不曉得任何醫院或診所
e. 其他（請說明）_____

7. 如果在你的住所附近，有一家診所或醫院有能夠說你所懂得的語言的醫療工作人員，你願意去那家診所或醫院嗎？ a. 願意 b. 不願意 c. 無所謂

你會比較喜歡醫療人員也是個女的嗎？ a. 會 b. 不會 c. 無所謂

你會覺得更舒服嗎，如果醫療人員是籍屬亞洲或太平洋諸島？
a. 會 b. 不會 c. 無所謂

8. 你認為你的同胞所面對的主要困難是什麼？（例如：健康，語言，移民/工作等）_____

_____

9. 你需要什麼樣的健康教育？_____

_____

各位

アジア系女性衛生プロジェクトのアンケートに御協力下さり，大変ありがとうございます。このアンケートは，アジア・太平洋諸島系女性の衛生問題をより良く理解する事を目的としています。私達は既に，私達のコミュニティーの健康管理をしている社会福祉官，医師，看護婦及び病院・クリニック関係者をインタビューしました。このアンケートで得られたデータは日本語による医療サービスを計画する上で非常に参考になります。アンケートは匿名でお答え下さい。

アジア系女性衛生プロジェクト代表
ミヤ・イワタキ

人種
年令
未婚・既婚
子供の数
居住地域
職業
学歴
話せる言語
宗教
滞米年数

1. 定期的に健康診断を受けていますか？ (a) はい (b) いいえ
早期癌発見テスト(子宮癌等の)をしたことがありますか？ (a) はい (b) いいえ (c) いつ
乳癌の検査をしたことがありますか？ (a) はい (b) いいえ (c) いつ

2. 避妊をしたことがありますか？ (a) はい (b) いいえ
答が(a)の場合，どんな避妊をしましたか？

(a) ピル
(b) コンドーム
(c) リング
(d) ゼリー
(e) ペッサリー
(f) 膣外射精
(g) オギノ式
(h) その他(明記して下さい)

あなたが使用している避妊法以外の方法を御存じですか？ (a) はい (b) いいえ (c) 答が(a)の場合明記して下さい。

3. 何か問題があった時誰と相談しますか？

(a) 夫/ボーイフレンド
(b) 両親
(c) 友人
(d) 牧師/神父
(e) 医師/他の医療関係者
(f) 同国籍の社会福祉官
(g) その他(明記して下さい)
(h) 頼りにできる人はいません

4. 現在何か健康上の問題がありますか？

5. 病気になった時，何処へ行きますか？

医療費はどうやって払いますか？

あなたが治療を受ける所には，あなたの母国語を
話す人がいますか？ (a) はい (b) いいえ

6. 満足のゆく医療を受けるのは難しいですか？ (a) はい (b) いいえ

答が(a)の場合，何故ですか？ (a) 医師は私の母国語を
話しません。
(b) 医療費が払えません。
(c) 交通の便が悪いです。
(d) 適当な施設を知りません。
(e) その他（明記して下さい。）

7. もし近所の病院やクリニックにあなたの母国語を話す
私達がいたらそこに行きますか？
(a) はい
(b) いいえ
(c) そのことは関係ありません。

医療関係者は女性の方が良いですか？ (a) はい (b) いいえ
(c) どちらでも良いです。

医療関係者がアジア・太平洋諸島系の
人だったら良いと思いますが？ (a) はい (b) いいえ (c) どちらでも
良いです。

8. あなたと同じ人種（国籍）の人々の間では，現在一番重要
な問題は何ですか？（例：健康，言語，差別，就業等）

9. どのような衛生教育が必要だと思いますか？

안녕 하십니까.

여러분께서 금번 저희 동양여성의 건강연구 과제를 도와주심을 진심으로 감사 드립니다. 금번 조사의 목적은 동양 여성 연구 과제에 동양여성의 건강 보급 필요성에 대해서 좀더 나은 이해를 드리는데 있읍니다. 저희들은 그간 우리사회에서 많이 수고 하고들 계시는 동양계의 많은 사회봉사자들, 사회건강 봉사자들, 의사 그리고 사회의 건강문제에 대해서 관심들이 깊은 많은 병원들과 진료소들을 상대로 쭉 면접도 해왔었읍니다. 금번 자료는 저희들에게 있어서 이중언어와 이중문화 건강 보급계획을 세우는데 커다란 도움이 될것 입니다. 또한 여러분들께서는 금번 조사에 관련해서 신원을 밝히실 필요가 없으시며, 여러분의 답변에 대해서 절대적인 비밀이 조중됩니다.
끝으로 여러분의 협조에 대해서 재 강사 드립니다.

Miya Iwataki for
Asian Women's Health Project

(동양 여성 건강 연구 과제)

동양 여성의 건강연구 과제

국적 _____
나이 _____
기혼/미혼 _____
아이수 _____
거주지 _____
직업 _____
교육수준 _____
언어(들) _____
종교 _____
마지막 기한 _____

1. 당신은 정기적으로 건강진단을 받습니까? a. 네 b. 아니오

당신은 유방검사를 받아보신적이 있습니까? a. 네 b. 아니오
c. 언제 _____

2. 당신은 (혹은 당신의 남편/남자친구) 피임에 관해서 혹은 임신을 누추기 위해서 어떤 방법들을 사용하신적이 있으십니까?
a. 네 b. 아니오

. 만약 위에서 네 하셨으면, 어떤 방법들을 이용하셨습니까?

a. 피임약
b. 콘돔
c. I.U.D.
d. Foam (폼)
e. Diaphram (막)
f. Withdrawal (회수)
g. Rhythm Method (추기법)
h. 그이외에 _____

당신은 당신이 사용하시고 있는 한방법외의 다른 방법에 대해서 잘 알고 계십니까? a. 네 b. 아니오
c. 만약 네 하셨으면 _____

3. 당신은 도움이 필요하실때 어디로 가십니까?

a. 남편/남자친구
b. 친구
c. 부모
d. 신부/목사
e. 의사/건강상담원
f. 당신주위의 사회 봉사자
g. 다른분이 계시면 서술해 주십시요 _____
h. 아무한테도 가지 않습니다.

4. 혹 당신을 괴롭히는 다른 건강문제나 질문은 없으십니까?

_____

_____

5. 당신은 건강문제에 대해서 도움이 요청될때 어디로 가십니까?

_____

당신은 어려한 건강 서비스에 대하여 어떻게 지불하고 계십니까?

_____

당신이 가시는곳에는 당신의 언어를 말씀하는 분들이 계십니까?
a. 네 b. 아니오

6. 당신은 좋은 건강 문제에 대해서 도움을 찾으시는데 어려움을 겪고 있읍니까?
혹 네 하셨으면 왜? a. 의사가 나의 언어를 말할줄 모름
b. 치료비를 지불할 능력이 없음
c. 교통편이 좋지 않음
d. 기관들에 대해서 모르고 있읍니다.
e. 다른 문제가 있으면 자세히 서술해 주십시요.

_____

7. 만약 어떤 진료소나 병원에 당신의 언어를 말할줄 아시는분이 계시면 당신은 그곳으로 가시겠읍니까? a. 네 b. 아니오 c. 상관 없음

당신은 건강봉사자가 여성여기를 더 원하십니까?
a. 네 b. 아니오 c. 상관 없음

당신은 통역해 건강봉사들하고 더 자유로우실수 있읍니까?
a. 네 b. 아니오 c. 상관 없음

8. 당신이 직면하고 있는 제일큰 문제는 (i.e. 건강, 언어, 이민, 직업) 무었 입니까?

_____

_____

9. 어떠한 건강 교육을 당신은 필요로하고, 또한 원하십니까?

_____

ยง่มกาด สุขพาย ทิ้ยู่
3860 พายตาดอัมกัก ชุมมีชุมตาพาพาชา
ฉีสีดอัมเย็ดอัดสี, กาลิฟัดญู่ 90008
โทละสัย (818) (495-6571)

สพายดีเยิ้ม,

ขอยมีหาม ทีชุ่ย พงกขอัยกัย ดีกาสาม สำรวด สุขพายญู่ เดชู้. ชุดัวกับ สาม สำรวดนี้ เยม ทิ้ญู่ เดชู้ ยู่ อัก เดกตัม ก่ง กัย ความ กัก กัม ขา สุขพาย, ญู่ สำ กัม คี สาม อาญ เยม กอย กัว ทิ้ญู่ เดชู้. พงก ขอัยกำ ดี สำ พาย กัย กัม เดชู้ ทาพาย กัม/ ผัวสัวญกกัม สู่ กัม, ชุมมีม, ถามสุขพาย เยะ: หาม หาม. ดีเหำ ทีดี ทิ้ญู่ หาม เยะ ยง่ม กาด สุขพาย ขัด เยม สำ ทิ้ญู่ สาม กาด สุขพายญู่ กับ ชุมมีม ขา พงก ขอัย. ส่อมี้ จาด จะ ชุย พงก ขอัย กัด ตั้ว เยม สาม มาชุย มำ ถามพาย เยะ: ยิ: เยมีกาญ ขา สาม ผู เย สุขพาย มาสู่ ชุมมีม ขา พงก ขอัย. ขี เยม พงก ขอัย ชุกาม หาม ยีสุด กัมกา พงก ขอัย สาย ถัม ขัด กับ กาย ขา หาม.

ขอยมี สามรวม มีขา หาม
Miyo Iwataki
ดีกาสามสุขพายญู่ เดชู้.

ຍ່ອມ ກາດ ສຸຂພາບ ເກ ຢູ່ ງ
3860 ພາບຕາ ເວ ສ ເກ ຊ ເມ ຊ ງ ພາ ຍ ງ
ສ ເ ເ ຍ ເ ເ ຊ, ກ ເ ເ ເ ເ 90008
ໂ ທ ລ ສ ເ (213) 295-6571

ສ ພ ເ ເ ຍ ເ ,

ຂ ຍ ເ ເ ເ ເ

4. ຕົກ ລົງ ການ ສຶກ ສາ ຝຶ ກ ອົບ ຮົມ ການ ຄວບ ຄຸ ມ ກໍ ເກີ ດ ຂຶ ້ ນ ໃ ນ ຂະ ແ ໜ ງ ການ.

ບ ໍ ່ ຕ ້ ອ ງ ກັ ງ ວົ ນ ໃ ຈ ເ ລ ີ ຍ ເ ພ ີ ່ ອ ສ ຸ ຂ ະ ພ າ ບ ຂ ອ ງ ທ ່ ານ ເ ອ ງ ເ ລ ີ ຍ . ຢ ່ າ ຫ ລ ີ ກ ລ ້ ຽ ງ ວ ິ ທ ີ ທ ີ ່ ທ ່ ານ ເ ຫ ັ ນ ວ ່ າ ເ ໝ າ ະ ສ ົ ມ ກ ັ ບ ທ ່ ານ ເ ອ ງ ເ ພ ື ່ ອ ຈ ະ ໄ ດ ້ ມ ີ ລ ູ ກ ຕ າ ມ ທ ີ ່ ທ ່ ານ ຕ ້ ອ ງ ກ ານ ແ ລ ະ ມ ີ ລ ູ ກ ໃ ນ ເ ວ ລ າ ທ ີ ່ ທ ່ ານ ຕ ້ ອ ງ ກ ານ . ທ ັ ນ ທ ີ ທ ີ ່ ທ ່ ານ ຢ ຸ ດ ໃ ຊ ້ ວ ິ ທ ີ ຄ ຸ ມ ກ ໍ ເ ນ ີ ດ ທ ່ ານ ກ ໍ ສ າ ມ າ ດ ຈ ະ ມ ີ ລ ູ ກ ໄ ດ ້ ເ ໝ ືອ ນ ກ ັ ນ ກ ັ ບ ຄ ົ ນ ອ ື ່ ນ ໆ ທ ີ ່ ບ ໍ ່ ໄ ດ ້ ໃ ຊ ້ ວ ິ ທ ີ ຄ ຸ ມ ກ ໍ ເ ນ ີ ດ ເ ລ ີ ຍ . ທ ່ ານ ສ າ ມ າ ດ ທ ີ ່ ຈ ະ ເ ຮ ັ ດ ໃ ຫ ້ ມ ີ ລ ູ ກ ໄ ດ ້ ຫ ລ ັ ງ ຈ າ ກ ທ ີ ່ ທ ່ ານ ໄ ດ ້ ຢ ຸ ດ ໃ ຊ ້ ວ ິ ທ ີ ຄ ຸ ມ ກ ໍ ເ ນ ີ ດ ແ ລ ້ ວ ເ ປ ັ ນ ເ ວ ລ າ ຫ ລ າ ຍ ປ ີ ເ ລ ີ ຍ ທ ີ ເ ດ ີ ວ . ທ ່ ານ ຄ ວ ນ ປ ຶ ກ ສ າ ກ ັ ບ ທ ່ ານ ໝ ໍ ຂ ອ ງ ທ ່ ານ ເ ພ ື ່ ອ ຫ າ ວ ິ ທ ີ ທ ີ ່ ດ ີ ທ ີ ່ ສ ຸ ດ ສ ໍ າ ລ ັ ບ ທ ່ ານ ເ ອ ງ ເ ລ ີ ຍ .

ຂ ອ ນ ໃ ຈ ການ ຮ ່ ວ ມ ມ ື ຂ ອ ງ ທ ່ ານ

Miya Iwataki

ຜ ູ ້ ອ ໍ ານ ວ ຍ ການ ໂ ຄ ງ ການ

เรียน คุณสุภาพสตรีทุกท่าน

ก่อนอื่นดิฉันขอขอบคุณท่านที่ได้ให้ความร่วมมือ เกี่ยวกับโครงการสำรวจสุขภาพสตรีชาว เอเชีย วัตถุประสงค์ของการสำรวจครั้งนี้ก็เพื่อให้โครงการดังกล่าว เข้าใจลึกซึ้งมากขึ้น เกี่ยวกับความต้องการของสตรีชาว เอเชียในปัญหาด้านสุขภาพ เราได้สัมภาษณ์นักสังคมสง เคราะห์ นักสุขาภิบาล และนายแพทย์ชาว เอเชียตลอดจนโรงพยาบาลและคลีนิคหลายแห่งที่ให้การรักษาต่อชุมชนของ เรา ผลของการสำรวจครั้งนี้จะเป็นโอกาสให้เราตั้งโครงการช่วย เหลือโดยใช้สองภาษาและวัฒนธรรมขึ้น เพื่อชุมชนของ เรา เรามิได้ให้ท่านแสดงหลักฐานใดๆจากตัวท่าน และ เราขอรับรองว่า เราจะเก็บคำตอบของท่านไว้ เป็นความลับที่สุด

ขอขอบคุณท่านอีกครั้งที่ได้ให้ความร่วมมือ.

Miya Iwataki

Miya Iwataki for
Asian Women's Health Project

โครงการส่งเสริมสุขภาพสตรีเอเชียและภาคพื้นแปซิฟิค

รหัสผู้ตอบ _____

สัญชาติ_____

อายุ _____

แผนงานหรือโสด_____

จำนวนบุตร _____

เขตที่อาศัย_____

อาชีพ_____

ระดับการศึกษา_____

ภาษาพูด_____

นับถือศาสนา_____

ระยะเวลาอยู่ในสหรัฐอเมริกา_____

1. ท่านได้รับการตรวจร่างกายสม่ำเสมอหรือเปล่า ก. ได้ ข. ไม่ได้
ท่านได้รับการตรวจเชื้อมะเร็งในมดลูกหรือเปล่า ก. ได้ ข. ไม่ได้ ค.จำได้เมื่อ_____
ท่านเคยได้รับการตรวจหน้าอกหรือไม่ ก. ได้ ข. ไม่เคย ค.จำได้เมื่อ_____

2. ท่านเคยใช้เครื่องป้องกันคุมกำเนิดหรือเปล่า ก. เคย ข. ไม่เคย
ถ้าเคยใช้ (ไม่ว่าสามีหรือเพื่อนชาย) ท่านใช้รองชนิดใด

ก. ยาเม็ด
ข. ปลอกยาง
ค. ไอ.ยู.ดี.
ง. ยาชนิดที่เป็นฟอง
จ. ถุงยาง
ฉ. ไม่ให้น้ำอสุจิเข้าไป
ช. ระยะระยะเดือน
ซ. อื่นๆ โปรดระบุ _____

ท่านคุ้นเคยกับวิธีอื่นนอกเหนือจากที่ท่านเคยใช้หรือไม่?
ก. ไม่เคย ข. เคย ค.จำไม่เคย โปรดระบุ _____

3. เมื่อท่านต้องการความช่วยเหลือท่านปรึกษาใครบ้าง

ก. สามี/เพื่อนชาย
ข. พ่อแม่
ค. เพื่อน
ง. พระ
จ. หมอ/นักสังคมสงเคราะห์
ฉ. นักสังคมสงเคราะห์ของคนไทย
ช. คนอื่นๆ ถ้ามีโปรดระบุ_____
ซ. ไม่มีใครที่ข้าพเจ้าไปหา

4. ท่านมีปัญหาหรือคำถามใดๆหรือเปล่าที่ท่านอยากทราบคำตอบ?

_____

_____

5. ท่านไปที่ไหนเมื่อต้องการรักษาทางด้านสาธารณสุข

_____

ท่านจ่ายค่ารักษาเท่าไหร่/อย่างไร

_____

สถานที่ที่ท่านไปหาหมอ มีคนพูดภาษาของท่านได้หรือไม่?

ก. มี ข. ไม่มี

6. ท่านมีปัญหา เรื่องหาที่รักษาดีๆหรือไม่

ก. มี ข. ไม่มี

ถ้ามี โปรดระบุ

ก.หมอไม่สามารถพูดภาษาเดียวกันได้

ข.ไม่มีเงินพอที่จะจ่ายค่ารักษา

ค.ไม่มีรถ

ง.ไม่ทราบเกี่ยวกับสถานที่บริการ

จ.อื่นๆ ถ้ามีโปรดระบุ

7. ถ้าหากมีคลินิคหรือโรงพยาบาลใกล้บ้านท่านมีนักสาธารณสุขที่พูดภาษาไทยได้ ท่านจะไปที่นั่นหรือไม่

ก. ไป ข. ไม่ไป ค. ไม่สำคัญ

ท่านต้องการนักสาธารณสุขที่เป็นสตรีหรือไม่

ก. ต้องการ ข. ไม่ต้องการ ค. ไม่สำคัญ

ท่านจะมีความสบายใจหรือไม่หากนักสาธารณสุขเป็นคนเอเชีย/ภาคพื้นแปซิฟิค

ก. สบายใจ ข. ไม่สบายใจ ค.ไม่สำคัญ

8. อะไรเป็นปัญหาใหญ่ในชุมชนของท่าน (อาทิ เรื่องสุขภาพ, ภาษา, กรมตรวจคนเข้าเมือง การหางานทำ)

_____

9. ความรู้ทางด้านสาธารณสุขชนิดใดที่ท่านต้องการทราบ?

_____

Asian Women Health Project
APPENDIX E (Continued)
Vietnamese Translation of Survey

Thưa Chị :

Cám ơn qui chị đã giúp đỡ chúng tôi trong Dự-Án Thăm-Dò Tình-Trạng Sức Khỏe của Phụ-Nữ Á-Châu. Cuộc thăm dò này nhằm mục-đích giúp Dự Án Về Tình-Trạng Sức Khỏe của Phụ-Nữ Á-Châu thông hiểu tường-tận hơn về các nhu-cầu sức khỏe của Phụ-Nữ Á-Châu/ Thái-Bình-Dương. Chúng tôi đã phỏng-vấn nhiều nhân-viên Á-Châu/ Thái-Bình-Dương, nhân-viên cộng-đồng và y-tế, và các bác-sĩ cũng như một số bệnh-viện , chẩn-y-viện mà đang cung-cấp sự chăm sóc về y-tế cho cộng-đồng chúng ta. Chúng tôi không yêu-cầu quí chị cho biết lý-lịch riêng tư của quí chị. Chúng tôi cam-đoan sự kín đáo triệt-để về các câu trả lời của quí chị.

Chân-thành cảm ơn sự giúp đỡ của Chị.

Miya Iwataki
Thay mặt Dự-Án Sức Khỏe Phụ-Nữ Á-Châu.

DỰ-ÁN SỨC KHỎE PHỤ-NỮ Á-CHÂU / THÁI-BÌNH-DƯƠNG

Người liên-lạc _____

Sắc dân, quốc-tịch _____
Tuổi _____
Tình-trạng hôn-nhân _____
Số con cái _____
Vị-trí địa-lý _____
Loại công việc làm _____
Trình-độ học-vấn _____
(các) ngôn-ngữ nói được _____
Tôn-giáo _____
Thời-gian cư ngụ trên Hoa-Kỳ _____

1.Chị có thường đi khám sức khỏe không ? a. Có b. Không
Chị có bao giờ thử ung-thư tử-cung không ? (pap smear)
a. Có b. Không c. Khi nào
Chị có bao giờ đi khám nhũ-hoa không ? a. Có b. Không c. Khi nào
2.Chị (hay bạn trai/ chồng của chị) có áp-dụng phương-pháp để ngừa hay hoãn mang thai hoặc sinh đẻ không ? a. Có b. Không
Nếu có, phương-pháp nào chị đã áp-dụng ?

a. Thuốc ngừa thai (Pills)
b. Bao dương-vật (Condoms)
c. Vòng xoắn (I.U.D.)
d. Thuốc bọt (Foam)
e. Vòng cách-mô (Diaphragm)
f. Phương-pháp tiền khoái/ thoái dương (Withrawal)
g. Phương-pháp định kỳ (Rhythm method)
h. Phương-pháp khác, xin cho biết _____

Chị có biết các phương-pháp khác ngoài phương-pháp chị đang áp-dụng không ?
a. Không b. Có c. Nếu có, xin cho biết _____
3. Chị thường gặp ai khi chị cần sự giúp đỡ ?

a. chồng / bạn trai.
b. cha mẹ
c. bạn bè
d. Linh mục / Mục-sư
e. Bác-sĩ / Nhân-viên y-tế
f. Nhân-viên xã-hội đồng quốc-tịch
g. Người khác, xin cho biết _____
h. Tôi không có ai để tới gặp cả

4. Có vấn-đề sức khỏe nào hay câu-hỏi gì mà chị thắc-mắc không ?

_____

_____

5. Chị đi đến đâu khi mà chị cần dịch-vụ y-tế ?_____

_____

Chị làm thế nào trả chi-phí cho những dịch-vụ này ? _____

Có ai nói cùng ngôn-ngữ của chị ở nơi đó không ? a. Có b. Không

6. Chị có gặp khó-khăn nào khi tìm sự chăm-sóc y-tế kiện-toàn không ?

a. Có b. Không

Nếu có, xin cho biết tại sao ? a. Bác-sĩ không nói cùng thứ tiếng với tôi.

b. Tôi không thể trang-trải cho các việc chăm sóc, khám bệnh này .

c. Tôi không có phương-tiện di chuyển.

d. Toi không biết nơi nào có cơ-sở y-tế.

e. vì lý-do khác, xin nêu ra _____

_____

7. Nếu một chẩn-y-viện hay bệnh-viện trong vùng của chị có nhân viên y-tế biết nói tiếng của chị, chị có đến nơi ấy không ?

a. có b. không c. không quan-hệ

Chị có thích nhân-viên y-tế phụ-nữ hơn không ?

a. có b. không c. không quan-hệ

Chị có thấy thoải mái hơn với một nhân-viên y-tế Á-Châu / Thái-Bình-Dương không ?

a. có b. không c. không quan-hệ

8. Trở-ngại chính nào mà đồng bào của chị gặp phải (ví dụ . y-tế, ngôn-ngữ, di-trú việc làm , v.v...)

_____

_____

9. Loại giáo dục y-tế nào mà chị cần hay mong muốn ?

_____

APPENDIX F

LARFPC STATISTICS: 1977 SPECIAL ASIAN REPORT

Asian Women Health Project
APPENDIX F

ASIAN - 1977 SPECIAL REPORT

January to December 1977

AGE RANGE/PRIMARY METHOD

AGE	ORAL	IUD	FOAM	CONDOM	DIA-PHRAGM	INJECTION	RYHTHM	OVUL-ATION	STERILI-ZATION	OTHER	NONE	ROW TOTALS
10 Or Under	0	0	0	0	0	0	0	0	0	0	0	0
11 - 14	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (99)	0 (0%)	0	0	0	0	0	3
15 - 18	131(72%)	6 (3%)	20 (11%)	9 (5%)	15 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	41 (98%)	223
19 - 24	728(65%)	76 (7%)	132 (12%)	79 (7%)	98 (9%)	0 (0%)	2 (1%)	0 (0%)	0 (0%)	4 (3%)	236 (96%)	1,255
25 - 34	890(47%)	288 (15%)	201 (11%)	459 (24%)	84 (4%)	0 (0%)	10 (4%)	0 (0%)	1 (0%)	8 (3%)	211(92%)	2,143
35 - 44	151(27%)	104 (18%)	66 (12%)	228 (40%)	15 (3%)	0 (0%)	6 (10%)	0 (0%)	1 (2%)	0 (0%)	51 (88%)	622
45 - 54	7 (9%)	10 (13%)	7 (9%)	54 (68%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (99)	81
55 Or Over	0 (0%)	0 (0%)	0 (0%)	1 (99%)	0 (0%)	0 (0%)	0	0	0	0	0	1
COLUMN TOTALS	1907(49%)	484 (13%)	426 (11%)	821 (21%)	216 (6)	0 (0%)	18 (4%)	0 (0%)	2 (0%)	13 (3%)	441(93%)	4,328

APPENDIX G

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
V.D. STATISTICS, 1976

ALL CASES OF VENERAL DISEASE FOR ASIANS IN LOS ANGELES COUNTY, 1976

Type of V.D.	Percentage of Asian Men Aged 15-44 Yrs.	Percentage of Asian Women Aged 15-44 Yrs.	Percentage of All Asians, Aged 15-44 Yrs.
Gonorrhea epidemiologic	0.52	0.47	0.99
Syphilis congenital	0	6.6	6.6
All forms of Syphilis	--	--	0.46
Syphilis epidemiologic	0.27	0.7	0.97
Syphilis early latent	0.44	0.5	0.94
Syphilis primary	0.2	1.7	1.9
Syphilis secondary	0.1	0	0.1
Gonorrhea infection	0.13	0.15	0.28

Source: Los Angeles County Department of Health Services, statistics on reportable disease by race, age and sex.

APPENDIX H

ILLEGITIMATE LIVE BIRTH BY RACE/AGE OF MOTHER
LOS ANGELES COUNTY
1974 - 1976

ILLEGITIMATE LIVE BIRTHS BY RACE/AGE OF MOTHER, LOS ANGELES COUNTY, 1974

	Raw Number	White	Mexican-American	Spanish Surname	Black	Chinese	Japanese	Pilipino	American Indian	Other Non-White	Unknown Race
Under 15 Years	294	16.67%	12.24%	18.03%	51.02%	0.00%	0.00%	0.34%	0.34%	1.36%	0.00%
15 - 19	8,310	20.40%	14.20%	20.30%	43.30%	0.04%	0.18%	0.25%	0.53%	0.54%	0.04%
20 - 24	6,883	17.70%	24.30%	16.30%	39.60%	0.10%	0.16%	0.36%	0.58%	0.67%	0.04%
25 - 29	3,456	17.10%	29.50%	15.50%	35.60%	0.09%	0.23%	0.41%	0.58%	0.84%	0.06%
30 - 34	1,459	15.70%	37.30%	13.30%	31.30%	0.27%	0.48%	0.34%	0.69%	0.48%	0.07%
35 - 39	575	13.00%	43.40%	14.00%	27.40%	0.00%	0.00%	0.52%	0.17%	1.22%	0.00%
40+	137	9.40%	46.70%	21.90%	20.40%	0.00%	0.00%	0.73%	0.00%	0.73%	0.00%
TOTAL Number	21,119	3,885	4,775	3,713	8,353	17	41	70	116	139	10
Percentage	100%	18.4%	22.6%	17.5%	39.5%	0.08%	0.19%	0.33%	0.55%	0.66%	0.05%

Source: Los Angeles County Department of Health Services, Division of Records and Statistics.

ILLEGITIMATE LIVE BIRTHS BY RACE/AGE OF MOTHER, LOS ANGELES COUNTY, 1975

	Raw Number	White	Mexican-American	Spanish Surname	Black	Chinese	Japanese	Pilipino	American Indian	Other Non-White	Unknown Race
Under 15 Years	270	18.1%	15.9%	15.9%	48.5%	0%	0%	0.37%	0.74%	0.37%	0%
15 - 19	8,320	19.0%	17.1%	21.7%	40.7%	0.02%	0.13%	0.18%	0.46%	0.61%	0.02%
20 - 24	7,330	17.7%	25.2%	17.1%	38.0%	0.01%	0.11%	0.33%	0.37%	0.97%	0%
25 - 29	3,674	17.0%	31.4%	14.1%	35.1%	0.05%	0.16%	0.30%	0.60%	1.09%	0%
30 - 34	1.575	15.6%	38.2%	13.9%	29.4%	0.13%	0.38%	0.57%	0.57%	1.08%	0.06%
35 - 39	626	15.0%	43.2%	13.4%	26.0%	0%	0.32%	0.80%	0.16%	0.96%	0%
40+	169	14.2%	45.5%	11.8%	26.6%	0%	0%	0.59%	1.18%	0%	0%
TOTAL Number	23,619	4,200	5,809	4,217	8,962	8	37	74	106	203	3
Percentage	100%	17.7%	24.5%	17.8%	37.9%	0.03%	0.16%	0.31%	0.45%	0.86%	0.01%

Source: Los Angeles County Department of Health Services, Division of Records and Statistics.

ILLEGITIMATE LIVE BIRTHS BY RACE/AGE OF MOTHER, LOS ANGELES COUNTY, 1976

	Raw Number	White	Mexican-American	Spanish Surname	Black	Chinese	Japanese	Pilipino	American Indian	Other Non-White	Unknown Race
Under 15 Years	307	15.6%	15.6%	13.3%	54.7%	0%	0%	0%	0.33%	0.33%	0%
15 - 19	9,684	19.2%	18.5%	21.4%	38.9%	0.05%	0.19%	0.38%	0.57%	0.55%	0%
20 - 24	9,081	17.2%	26.0%	17.3%	37.6%	0.08%	0.10%	0.25%	0.56%	0.69%	0%
25 - 29	4,625	16.6%	30.9%	15.6%	34.0%	0.11%	0.35%	0.61%	0.50%	1.17%	0%
30 - 34	1,888	14.3%	38.6%	14.4%	29.3%	0.11%	0.32%	0.58%	0.69%	1.54%	0.05%
35 - 40	770	12.4%	43.9%	14.5%	25.7%	0.26%	0.26%	0.26%	0.39%	2.21%	0%
40+	166	11.4%	43.3%	19.8%	22.2%	0%	0.60%	0%	0%	2.41%	0%
TOTAL Number	26,527	4,641	6,787	4,839	9,718	21	52	101	146	221	1
Percentage	100%	17.5%	25.5%	18.2%	36.6%	0.08%	0.20%	0.38%	0.55%	0.83%	0.0%

Source: Los Angeles County Department of Health Services, Division of Records and Statistics.

APPENDIX I

FETAL DEATHS BY ETHNICITY
LOS ANGELES COUNTY, 1970 - 1976

Fetal Deaths by Ethnicity, Los Angeles County

	Total	White	Spanish	Black	Other Non-White	Asian	Pilipino	Japanese	Chinese
1970	1,612	816	388	342	50	INA	INA	INA	INA
Rate	12.2	11.0	11.5	17.9	9.8	INA	INA	INA	INA
Percent	100	50.6	24.1	21.2	3.1	INA	INA	INA	INA
1971	1,408	584	426	348	23	21	INA	INA	INA
Rate	12.1	10.1	11.8	21.0	9.5	7.8	INA	INA	INA
Percent	100	41.5	30.3	24.7	1.6	1.5	INA	INA	INA
1972	1,134	435	388	268	28	13	INA	INA	INA
Rate	10.6	8.6	10.6	17.8	10.8	4.9	INA	INA	INA
Percent	100	38.4	34.2	23.6	2.5	1.1	INA	INA	INA
1973	1,261	465	468	286	21	16	INA	INA	INA
Rate	INA	INA	INA	INA	INA	INA	INA	INA	INA
Percent	100	36	37	22	1.6	1.2	INA	INA	INA
1974	1,195	461	441	242	22	—	14	7	8
Rate	11	11.0	9.8	15.3	8.7	—	11.8	6.7	11.3
Percent	100	38.6	36.9	20.3	1.8	—	1.2	0.6	0.7
1975	1,180	351	460	275	40	—	16	13	25
Rate	10.6	8.6	9.6	16.8	13.0	—	13.5	14.8	40.7
Percent	100	29.7	39.0	23.3	3.4	—	1.4	1.1	2.1
1976	1,224	375	504	291	22	—	21	8	3
Rate	10.6	9.1	9.9	17.1	6.8	—	14.9	9.0	3.6
Percent	100	13.6	41.2	23.8	1.8	—	1.7	0.7	0.2

Sources: Vital Statistics, Los Angeles County Department of Health Services, Division of Records and Statistics, 1970, 1971, 1972, 1973, 1974, 1975, 1976.

APPENDIX J

LIVE BIRTH BY ETHNICITY

LOS ANGELES COUNTY, 1970 - 1976

Live Births by Ethnicity, Los Angeles County

	Total	White	Spanish	Black	Other Non-White	Asian	Pilipino	Japanese	Chinese
1970	131,915	73,903	33,706	19,150	5,120	INA	INA	INA	INA
Rate	18.8	INA	INA	25.1	19.5	INA	INA	INA	INA
Percent	100	56	25.6	14.5	3.9	INA	INA	INA	INA
1971	115,956	58,080	36,207	16,540	2,420	2,691	INA	INA	INA
Rate	INA	INA	INA	INA	INA	INA	INA	INA	INA
Percent	100	50.1	31.2	14.3	2.1	2.3	INA	INA	INA
1972	107,249	50,340	36,601	15,018	2,589	2,665	INA	INA	INA
Rate	INA	INA	INA	INA	INA	INA	INA	INA	INA
Percent	100	47	34.1	14	2.4	2.5	INA	INA	INA
1973	111,353	45,581	43,993	16,173	3,157	2,411	INA	INA	INA
Rate	INA	INA	INA	INA	INA	INA	INA	INA	INA
Percent	100	41	40	14	2	2.1	INA	INA	INA
1974	108,324	41,940	45,113	15,799	2,534	INA	1,189	1,038	711
Rate	15.5	9.1	32.5	21.0	NA	--	NA	NA	NA
Percent	100	38.7	41.6	14.6	2.3	--	1.1	1.0	0.7
1975	110,960	40,376	47,979	16,340	3,087	--	1,186	877	615
Rate	15.9	8.9	34.6	21.8	NA	--	NA	NA	NA
Percent	100	36.3	43.2	14.7	2.8	--	1.1	0.8	0.6
1976	115,590	41,366	50,863	16,976	3,253	--	1,410	884	838
Rate	16.5	9.0	36.6	22.6	NA	--	NA	NA	NA
Percent	100	35.8	44	14.7	2.8	--	1.2	0.8	0.7

Sources: Vital Statistics, Los Angeles County Department of Health Services, Division of Records and Statistics, 1970, 1971, 1972, 1973, 1974, 1975, 1976.